



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 8, 2023

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: November 6, 2023

Dear Administrator:

On December 7, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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

Electronically delivered

December 8, 2023

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: Reinspection Results
Event ID: WE6912

Dear Administrator:

On December 7, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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

Electronically delivered
November 14, 2023

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: November 6, 2023

Dear Administrator:

On November 6, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 6, 2024, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 6, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

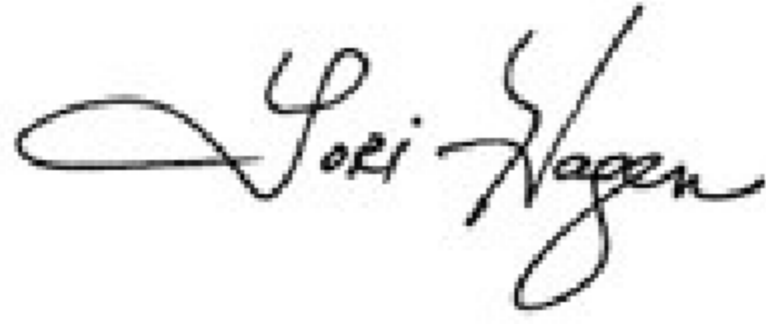
Mayo Clinic Health System - Lake City

November 14, 2023

Page 4

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is written in a cursive style with a large, looping initial "L".

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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Electronically delivered
November 14, 2023

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: State Nursing Home Licensing Orders
Event ID: WE6911

Dear Administrator:

The above facility was surveyed on November 1, 2023, through November 6, 2023, 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.

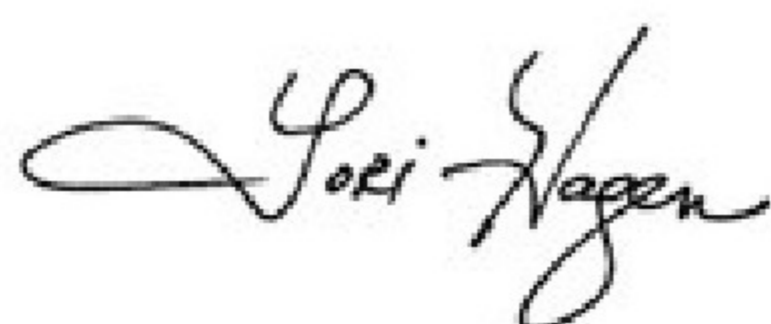
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is written in a cursive style with a large initial "L" and "H".

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/02/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2023
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NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 11/1/23, 11/2/23 and 11/6/23, 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.</p> <p>The following complaints were reviewed: H52186667C (MN97931 and MN97974) H52187006C (MN98329) with a deficiency cited at F552, F609, F623, F625, and F626. 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.</p> <p>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.</p>	F 000		
F 552 SS=D	<p>Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)</p> <p>§483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:</p> <p>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>§483.10(c)(4) The right to be informed, in</p>	F 552		11/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/22/2023
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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 552	<p>Continued From page 1</p> <p>advance, of the care to be furnished and the type of care giver or professional that will furnish care.</p> <p>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to obtain informed consent for a psychotropic medication (medication that affects behavior, mood thought or perception) for 1 of 1 residents (R1) reviewed for neglect in relation to medications.</p> <p>Findings include:</p> <p>R1's admission, Minimum Data Set (MDS), dated 10/16/23, indicated R1's cognition was moderately impaired. R1's diagnoses included stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further the MDS indicated R1 to had delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's nurse practioner provider note dated 10/17/23, indicated R1 to be confused and very pleasant. Reported of yelling and swinging at staff while trying to help R1 get her clothes rearranged. Therapy indicated R1 can't focus on a single task with difficulty to redirect and had struggles with sleep. The note indicated a new order to restart melatonin (sleep supplement), start mirtazapine (antidepressant) 7.5 milligrams (mg) at HS (hour of sleep) and Seroquel</p>	F 552	<p>On 11/1/2023, 11/2/2023 and 11/6/2023, MDH completed a standard abbreviated survey and noted the facility failed to obtain informed consent for a psychotropic medication for 1 of 1 resident's reviewed for neglect in relation to medications.</p> <p>Resident was discharged from the facility and did not return so consent could not be revised.</p> <p>Psychopharmacologic Drug Use policy and procedure was reviewed and remains current. Facility will re-educate staff regarding the requirement to obtain consent prior to psychotropic drug use. Residents with psychotropic medications will have their chart audited weekly for 2 months to ensure informed consents are obtained for psychotropic medications. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ongoing compliance and those solutions are sustained.</p> <p>Date corrected 11/27/2023.</p> <p>Director of Nursing or designee will be responsible to ensure compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 552	<p>Continued From page 2 (antipsychotic medication) 12.5 mg was considered for agitation but family member (FM)-A was not in agreement.</p> <p>R1's medical record lacked informed consent for the use of psychotropic medications.</p> <p>R1's medication administration record (MAR), dated October of 2023, indicated R3 received Seroquel 12.5 mg on 10/17/23 at 4:30 p.m.</p> <p>R1's physician provider note dated 10/18/23 indicated R1 had entered the therapy office and refused to leave, stating that cars were being sold right from the nursing home parking lot, had escalating anxiety and agitation following R1's admission to the facility following a hospital stay from stroke, was started on mirtazapine 10/17/23 as well as melatonin. The note indicated Seroquel was discussed with FM-A and was declined. R1 was focused on her car during the visit, stating her jeep was sold from the parking lot. Additionally the not indicated follow up with FM-A and FM-A agreed there was increased agitation within the last day, and R1 had been in distress with these worries. FM-A noted R1 had gotten very into specific news stories in the past and would get worked up on some topics and would be difficult for R1 to break that focus. The provider noted a black box warning with Seroquel, so would not pursue, will start Ativan (antianxiety medication) 0.5 mg and R1 had a planned follow up on 10/23/23.</p> <p>During an interview on 11/1/23 at 3:56 p.m. FM-A stated someone at the facility called on 10/18/23 and was told R1 locked herself in the therapy office so the facility gave R1 some Seroquel. I got a call from the nurse practioner (NP)-A on</p>	F 552		

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F 552	<p>Continued From page 3</p> <p>10/17/23 about R1 starting Seroquel and I told her no. FM-A stated R1 had stage four kidney disease and Seroquel is not good for the kidney function.</p> <p>During an interview on 11/2/23 at 12:01 p.m., director of nursing (DON) stated R1 was prescribed Seroquel on 10/17/23 and it was given that day without an informed consent in place. DON indicated an informed consent must be obtained prior to administering any antipsychotic.</p> <p>Facility policy, "Psychopharmacological Drug Use," reviewed 10/6/22, indicated residents are free from the use of any psychotropic medication for purposes of discipline or convenience and from medications not required to treat medical symptoms. 1. Psychopharmacologic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotic's, and "other" drugs that affect behavior ... 4. The resident or his/ her representative will be provided information regarding the need for, the desired effects and the potential unwanted side effects of the medication. This enables the resident or his/ her representative to make an informed decision regarding the use of psychoactive medication. 5. Informed consent for psychoactive medication will be obtained from the resident or legal representative for medications used to alter behavior. 6. Consent will be obtained as verbal/ telephone consent or a written signed consent.</p>	F 552		
F 609 SS=D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p>	F 609		11/27/23

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F 609	<p>Continued From page 4</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure allegations of staff to resident abuse were immediately reported to the State Agency (SA) no later than 2 hours after the knowledge of the allegation of abuse, for 1 of 1 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>Facility reported incident (FRI) submitted on 11/6/23 at 11:46 a.m., identified that on 10/21/23 at 6:03 p.m., the facility was notified by the</p>	F 609	<p>On 11/1/2023, 11/2/2023 and 11/6/2023, MDH completed a standard abbreviated survey and noted the facility failed to ensure allegations of staff to resident abuse were immediately reported to the State Agency no later than 2 hours after the knowledge of the allegation of abuse, for 1 of 1 resident's reviewed for abuse. Administrator will review policies and procedures regarding reporting of all alleged abuse, neglect, or mistreatment. Allegations of abuse, neglect, or</p>	

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F 609	<p>Continued From page 5</p> <p>emergency room (ER) nurse practitioner (NP)-A that an unidentified staff person at the facility "manhandled" R1 and "they have it on video." The report further indicated the ER staff refused to show the facility the footage without a subpoena, facility interviewed staff that worked that weekend with R1 and were unable to find an alleged perpetrator (AP).</p> <p>R1's admission, Minimum Data Set (MDS), dated 10/16/23, indicated R1's cognition was moderately impaired. R1's diagnoses included stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further indicated R1 to have delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's progress note dated 10/23/23 at 12:20 p.m., indicated the DON received a phone call from county social services (CSS)-A about how Mayo security had a video of facility staff "manhandling resident using excessive force." R1 was discharged to the ER on 10/21/23.</p> <p>During an interview on 11/2/23 at 12:01 p.m., DON indicated that someone from the county had called her on 10/23/23 and reported there was video surveillance that R1 was manhandled by one of our staff over the weekend. DON indicated this allegation was not reported to the state agency.</p> <p>Facility policy, "Vulnerable Adult-Abuse Prohibition Plan," revised 10/6/22, indicated a Purpose: Ebenezer skilled nursing facilities supports "Zero Tolerance" for resident/patient abuse, neglect, exploitation, mistreatment and/or misappropriation of property. To provide our residents with a safe, secure environment free</p>	F 609	<p>mistreatment will be reported to the state agency within two hours.</p> <p>Facility staff will report vulnerable adult incidents to Director of Nursing or Administrator via phone, not email. Administrator or designee will re-educate staff on the two-hour timeframe for reporting allegations of abuse, neglect, or mistreatment. Staff will be re-educated on the company policy and procedures surrounding such allegations. Audits will be conducted weekly for two months to ensure allegations of abuse, neglect, or mistreatment are reported within two hours. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ongoing compliance and those solutions are sustained.</p> <p>Deficiency to be corrected 11/27/2023. Director of Nursing or designee will be responsible to ensure compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 609	Continued From page 6 from maltreatment. Procedure indicated mandated reporters in skilled nursing facilities ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported, and a report made immediately, but not later than 2 hours after the allegation is made.	F 609		
F 623 SS=D	<p>Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)</p> <p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <ul style="list-style-type: none"> (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. <p>§483.15(c)(4) Timing of the notice.</p> <ul style="list-style-type: none"> (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- <ul style="list-style-type: none"> (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of 	F 623		11/27/23

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F 623	<p>Continued From page 7</p> <p>this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, 	F 623		

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F 623	<p>Continued From page 8</p> <p>codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long-Term Care (LTC) ombudsman of a facility-initiated transfer for 1 of 1 residents (R1) who was transferred to an acute care facility on an emergency basis reviewed for hospitalization.</p> <p>Findings include:</p> <p>R1's admission, Minimum Data Set (MDS), dated 10/16/23, indicated R1's cognition was</p>	F 623	<p>Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not</p>	

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F 623	<p>Continued From page 9</p> <p>moderately impaired and had diagnoses to include stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further indicated R1 to have delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's progress note dated 10/21/23 at 7:15 p.m., indicated staff had called security guard (SG)-A and was sitting with R1 by large TV. Licensed practical nurse (LPN)-A came down the hallway, R1 did seem a little calmer. R1 entered back into hallway and began to yell at other residents and staff. LPN-A had placed a call to on call provider and agreed that R1 should go over to ER and be placed on 72-hour hold, as R1 had this type of behavior most of the day. LPN-A placed a call to the ER and talked with the NP from the ER. NP-A stated they could not place R1 on a hold if she did not meet the requirements. LPN-A then called the DON who stated to take R1 to over to ER as R1 was a harm to herself and others. No bed hold was placed. R1 was then assisted over to ER with LPN-A and SG-A.</p> <p>R1's discharge MDS dated 10/21/23, indicated R1 had an unplanned discharge to a short term general hospital with a return not anticipated.</p> <p>R1's medical record lacked documentation the notice of the hospital transfer was sent to the LTC Ombudsman.</p> <p>During an interview on 11/2/23 at 11:12 a.m. social worker (SW)-A indicated that [R1] had a facility-initiated transfer to the emergency room (ER) on 10/21/23. SW-A indicated it would be her responsibility to notify the ombudsman in this case and that she had not done so.</p>	F 623	<p>constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agent's findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs.</p> <p>On 11/1/2023, 11/2/2023 and 11/6/2023, MDH completed a standard abbreviated survey and noted the facility failed to notify the Long-Term Care ombudsman of a facility-initiated transfer for 1 of 1 resident who were transferred to an acute care facility on an emergency basis reviewed for hospitalization.</p> <p>All resident transfer/discharge records for the last month were reviewed to ensure appropriate notices were provided to the ombudsman.</p>	

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F 623	<p>Continued From page 10</p> <p>During an interview on 11/2/23 at 3:02 p.m., director of nursing (DON) confirmed the above findings and indicated she would expect staff would ensure the required notification to the LTC Ombudsman would have been completed.</p> <p>During an email correspondence on 11/8/23, at 1:45 p.m. LTC ombudman (O)-A indicated a hospital transfer notification was not received for R1's transfer on 10/21/23.</p> <p>Facility policy, "Transfer and Discharge from the Facility," revised April 2020, lacked evidence of a procedure or process for notifying the LTC ombudsman for emergency transfers. The facility sends a list of residents who have been discharged and transferred out of the facility to the ombudsman on a monthly basis.</p>	F 623	<p>Transfer/Discharge from the facility policy was reviewed and revised to include emergency transfer situations. Administrator will re-educate Social Service staff on policy changes and the requirement to notify the ombudsman of emergency transfers. Chart audits will be conducted weekly for two months for any resident that transferred/discharged the past week to ensure that transfers/discharges, or emergency transfers are sent to the Long-Term Care ombudsman. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ongoing compliance and those solutions are sustained. Administrator or designee will be responsible to ensure compliance. Date corrected 11/27/2023.</p>	
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding</p>	F 625		11/27/23

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F 625	<p>Continued From page 11</p> <p>bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure a written notice of bed hold was provided in a timely manner for 1 of 1 resident (R1), reviewed for hospitalization.</p> <p>Findings include:</p> <p>R1's admission, minimum data set (MDS), dated 10/16/23 indicated R1's cognition was moderately impaired and had diagnosis to include stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further indicated R1 to have delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's progress note dated 10/21/23 at 7:15 p.m. indicated staff had called security guard (SG)-A and was sitting with R1 by large TV. Licensed practical nurse (LPN)-A came down the hallway, R1 did seem a little calmer. R1 entered back into hallway and began to yell at other residents and staff. LPN-A had placed a call to on call provider and agreed that R1 should go over to ER and be placed on 72-hour hold, as R1 had this type of</p>	F 625	<p>On 11/1/2023, 11/2/2023 and 11/6/2023, MDH completed a standard abbreviated survey and noted the facility failed to ensure a written notice of bed hold was provided in a timely manner for 1 of 1 resident's reviewed for hospitalization. All resident records that have been sent to the hospital in the last month were reviewed to ensure appropriate bed hold notices were provided to the resident/representative. Bed Hold policy has been reviewed and revised so both the resident and social services will receive a copy of the bed hold agreement. Facility will re-educate staff regarding the new Bed Hold policy and the requirement to obtain a written notice of bed hold in timely manner. Chart audits of residents sent to the hospital that week will be conducted weekly for two months to ensure a written notice of bed hold is provided to the resident in a timely manner. Results of the</p>	

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F 625	<p>Continued From page 12</p> <p>behavior most of the day. LPN-A placed call to ER and talked with NP from ER. NP-A stated they could not place R1 on a hold if she did not meet the requirements. LPN-A then called the DON who stated to take R1 to over to ER as R1 was a harm to herself and others. No bed hold was placed. R1 was then assisted over to ER with LPN-A and SG-A.</p> <p>R1's discharge MDS dated 10/21/23 indicated R1 had an unplanned discharge to a short term general hospital with a return not anticipated.</p> <p>R1's medical record was reviewed and lacked evidence a written notice of the facility bed hold policy and/or procedure had been provided to R1/resident representative prior to being transferred to the ER. Further lacked evidence that the facility attempted to send or provide notice to R1 or R1's representative within 24 hours after being admitted.</p> <p>During an interview on 11/2/23 at 11:12 a.m. social worker (SW)-A indicated that [R1] had a facility-initiated transfer to the emergency room (ER) on 10/21/23. SW-A indicated if the nurse is not able to get a bed hold, I would be the one to follow up on that. I would then have to reach out to the family, if we got a verbal, I would follow up with that to get a written bed hold. SW-A stated, I did not follow up with [R1's] bed hold, on this because I was told we were not accepting [R1] back.</p> <p>During an interview on 11/2/23 at 3:02 p.m., director of nursing (DON) confirmed [R1] had a facility-initiated discharge and indicated there was not a written bed hold for [R1's] transfer to the ER.</p>	F 625	<p>audits will be reviewed at QAPI for follow up and recommendations to ensure ongoing compliance and those solutions are sustained.</p> <p>Date corrected 11/27/2023.</p> <p>Director of Nursing or designee will be responsible to ensure compliance.</p>	

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F 625	Continued From page 13 Facility policy, "Bed Hold Agreement Policy," revised on 06/20, identified upon admission to the facility and at the time hospitalization or therapeutic leave, the resident and/or resident representative is informed of the Bed Hold Policy. If a resident is hospitalized or requests a therapeutic leave, Facility will hold the bed for the resident unless otherwise notified by the resident and/or resident representative.2. At the time of each transfer, the Bed Hold Agreement is completed and signed by the resident and/or resident representative prior to the beginning of the leave.3. In cases of emergency transfer, notice "at the time of transfer" means that the resident and resident representative is provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital.7. If the Bed Hold Agreement is not signed prior to the transfer, Social Services and/or designee will contact the resident representative to discuss bed hold and document the conversation in Point Click Care. The Bed Hold form needs to be completed and faxed, mailed, or emailed to the resident and/or resident representative to obtain signature.	F 625		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.	F 626		11/27/23

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F 626	<p>Continued From page 14</p> <p>(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-</p> <p>(A) Requires the services provided by the facility; and</p> <p>(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.</p> <p>(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.</p> <p>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to readmit a resident (R1) to return to the facility after a transfer to the attached hospital emergency department (ED) for an increase in R1's behaviors for the third time in less than 24 hours. The facility would not allow R1 to return to the facility even though R1 was deemed medically stable, and the facility was able to meet the needs of the resident as</p>	F 626	<p>On 11/1/2023, 11/2/2023 and 11/6/2023, MDH completed a standard abbreviated survey and noted the facility failed to readmit a resident to return to the facility after a transfer to the attached hospital emergency department for an increase in R1's behaviors for the third time in less than 24 hours. The facility would not allow R1 to return to the facility even though R1</p>	

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F 626	<p>Continued From page 15 identified by their facility assessment.</p> <p>Findings include:</p> <p>R1's after visit summary (AVS), dated 10/10/23, indicated on 9/26/23 R1 was admitted for a stroke and presented with altered mental status. During the hospital course on 9/27/23, R1 pulled out her nasogastric (NG) tube, restraints were placed and R1 improved but struggled with following and understanding commands. On 9/29/23, R1 had goal directed questions, but was paranoid. R1 had intravenous (IV) contrast and poor oral intake resulting in acute on chronic kidney disease. R1 had two unresponsive episodes with an incontinent bowel movement thought to be vasovagal (sudden drop-in heart rate in pulse leading to loss of consciousness). R1's cognition indicated poor safety awareness, poor attention/concentration, short term memory loss and impulsivity. Further the AVS indicated R1 required daily inpatient skilled nursing and rehabilitation services.</p> <p>R1's admission, Minimum Data Set (MDS), dated 10/16/23, indicated R1's cognition was moderately impaired and had diagnoses to include stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further indicated R1 to have delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's admission assessment dated 10/10/23, indicated R1 had mild left sided weakness, required extensive assist of one person with transfers, dressing and personal hygiene, needed total dependence of one staff with toileting and no mobility device used. R1 was alert and oriented to person, displayed confusion, restlessness,</p>	F 626	<p>was deemed medically stable, and the facility was able to meet the needs of the resident as identified by their facility assessment.</p> <p>Transfer and Discharge from the facility policy revised to include Notice of Transfer or Therapeutic Leave form. Residents who have facility-initiated discharges will be able to return to the facility if they are medically stable. Facility will re-educate staff regarding the updated policy and Notice of Transfer or Therapeutic Leave form and the facility readmission criteria and requirements when not appropriate for readmission to the facility.</p> <p>Chart audits will be conducted weekly for two months on any resident that is hospitalized during the past week to ensure facility policy is followed on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ongoing compliance and those solutions are sustained.</p> <p>Date corrected 11/27/2023. Director of Nursing or designee will be responsible to ensure compliance.</p>	

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F 626	<p>Continued From page 16</p> <p>impulsivity and unsafe decision-making due to cognitive impairment.</p> <p>R1's care plan dated 10/16/23 indicated Mood/behavior: I have potential for changes in my mood related to admission to care center, new stroke, impaired cognition. I at times will refuse cares that are offered by staff, I am continuing to adjust to placement at CC. I often am unable to carry on conversation due to being easily distracted and impaired thought processes. I often speak about my sons whom I lived with prior. My behaviors have escalated since my admission. I have had episodes of elevated agitation, inability to focus, insomnia, verbal threats, paranoia, and disruptive behaviors involving other residents. I am also making frequent racial remarks and slurs towards staff that are African American heritage. Interventions included to: 10/16/23, administer medications as ordered, observe for signs and symptoms of mania or hypomania, racing thoughts or euphoria, increased irritability, frequent mood changes, pressure speech, flight of ideas, marked change in need for sleep, agitation, or hyperactivity and monitor/record/report to MD mood patterns s/sx of depression, anxiety, sad mood as per facility behavioral monitoring protocols. On 10/18/23, attempt nonpharmacological interventions, to ask me about my cat and offer me a snack or beverage. On 10/19/23 to call 911 if physically aggressive behavior and inability to redirect behaviors of attempted elopement.</p> <p>R1's progress note dated 10/13/23 at 10:03 p.m., indicated R1 was assisted to bed and stated, "I do want to apologize because I just don't like asking for help." R1 became teary eyed and stated, "I just miss my cat." Licensed practical</p>	F 626		

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F 626	<p>Continued From page 17</p> <p>nurse (LPN)-A sat with R1 to let R1 express her feelings and spoke about her cat. R1 appeared to be in better spirits.</p> <p>R1's behavior progress note dated 10/15/23 at 6:39 a.m., indicated registered nurse (RN)-A overheard an aide asking for assist in R1's room. R1 was seated at the edge of her bed ready to transfer to wheelchair and was being resistive stating the media is influencing the facility and R1 was looking for her cat. R1 was not willing to lay down or get in her wheelchair. R1 stated she would yell if staff did not leave her alone.</p> <p>R1's behavior progress note dated 10/15/23 at 6:33 p.m., indicated R1 was wandering into other resident rooms looking for her room, R1 was redirected. The progress note did not identify if this was effective.</p> <p>R1's progress note dated 10/16/23 at 6:12 a.m., indicated R1 self-transferred to the bathroom and R1 transferred to her wheelchair and was brought out by the nurses station.</p> <p>R1's behavior progress note, dated 10/16/23 at 8:38 a.m., indicated staff handed out R1's breakfast tray, R1 hollered at staff, "I don't want that. I have a hat and you are from a poor country. I hate poor countries so that means I hate you." R1 continued to holler at staff until LPN-B came in and asked staff to leave the room. LPN-B took R1's tray as R1 refused to eat. Redirection was attempted and not effective, so staff left the room.</p> <p>R1's behavioral progress note, dated 10/16/23 at 9:00 a.m., indicated R1 was self-transferring and walking around the unit independently refusing to</p>	F 626		

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F 626	<p>Continued From page 18</p> <p>let the aides help her because, "they're from a different country and holding me here against my will. They are invading me here and I'm from the united states of America." R1 was worked up and tried to enter an other resident's rooms screaming at LPN-B that R1 owned them, and she could go in them. R1 was yelling about wanting her cat and wanting to save her cat from the invasion that's taking place. Interventions listed were redirection, reapproach, food and warm blanket that were indicated as ineffective. R1 asked to go for a walk and agreed to lay in bed which was listed as effective.</p> <p>R1's behavior progress note dated 10/16/23 at 1:53 p.m., indicated R1 was walking around the hall without assist hollering at staff how they are keeping her here, redirection was attempted and was ineffective.</p> <p>R1's behavior progress note dated 10/16/23 at 2:04 p.m., indicated R1 was using the bathroom and was shouting and hollering making remarks to staff, throwing her sweater at staff, and raising her hand to staff. Redirection was attempted and listed as ineffective.</p> <p>R1's progress note dated 10/16/23 at 8:53 p.m., indicated R1 was very hard to redirect during the shift. R1 wandered into other resident rooms, upon redirection R1 would yell at staff and call them names. R1 would self transfer and yell at staff if they tried to walk with R1 or get R1 back in the wheelchair. R1 often did not make sense, often yelling about her cat. After listening to staff concerns about risk of falling R1 transferred to her wheelchair and was brought up to the nurse's station.</p>	F 626		

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F 626	<p>Continued From page 19</p> <p>R1's behavior progress note dated 10/17/23 at 12:30 a.m., indicated R1 was going through her roommate's closet, trying on roommate's clothes and walking around her room alone. Intervention: redirected and educated on touching others personal items, was able to be redirected back to bed.</p> <p>R1's behavior progress note dated 10/17/23 at 8:06 a.m., indicated R1 was lying in bed sideways with her pad and pants pulled down with her legs on her roommates bed and had roommates garbage can as a pillow. LPN-C attempted to redirect R1 to her own bed and R1 called LPN-C "stupid", and that LPN-C is only here to "make her life hell", not helping her. LPN-C left the room once R1 went to her own bed.</p> <p>R1's nurse practitioner provider note, dated 10/17/23, indicated R1 to be confused and very pleasant. Reported of yelling and swinging at staff while trying to help R1 get her clothes rearranged. Therapy indicated R1 can't focus on a single task, was difficult to redirect and struggled with sleep. The note indicated a new order to restart melatonin (sleep supplement), start mirtazapine (antidepressant) 7.5 milligrams (mg) at HS (hour of sleep) and Seroquel (antipsychotic medication) 12.5 mg was considered for agitation but family member (FM)-A was not in agreement.</p> <p>R1's progress note dated 10/17/23 at 4:30 p.m., indicated R1 was given Seroquel, a subsequent note at 8:00 p.m. indicated the medication was ineffective.</p> <p>R1's behavior progress note dated 10/18/23 at</p>	F 626		

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F 626	<p>Continued From page 20</p> <p>1:20 p.m., indicated R1 was seated in the common area and began yelling at the TV and a staff member attempted to console R1 but it led to R1 yelling more. R1 was given space and R1 was moved to a different chair. A staff member went to go get a warm blanket and R1 was no longer in the chair. R1 was found at the physical therapy (PT) desk yelling about the facility, the food, and stated she would report them all to the state. Intervention was to have a 1:1 and during this time and R1 stated, "the Mexican and the black people here are ruining our country," and made a remark about employees here of color are going to "strap bombs on their chest." Interventions attempted were empathetic listening, calm therapeutic communication, and redirection of conversation. A hospitality aide sat with R1 and massaged lavender lotion on her hands which was effective at times before R1 became worked up again. R1 was seeing a provider at 1:30 p.m.</p> <p>R1's provider note dated 10/18/23, indicated R1 had entered the therapy office and refused to leave, stating that cars were being sold right from the nursing home parking lot. R1 had escalating anxiety and agitation following R1's admission to the facility following a hospital stay from stroke, was started on mirtazapine 10/17/23 as well as melatonin. The note indicated Seroquel was discussed with family member (FM)-A and was declined. R1 was focused on her car during the visit, stating her Jeep was sold from the parking lot. Additionally, the note indicated to follow up with FM-A and FM-A agreed there was increased agitation within the last day, and R1 had been in distress with these worries. FM-A noted R1 had gotten into very specific news stories in the past and would get worked up on some topics and</p>	F 626		

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F 626	<p>Continued From page 21</p> <p>would be difficult for R1 to break that focus. The provider noted a black box warning with Seroquel, so would not pursue. The note indicated to start Ativan (antianxiety medication) 0.5 mg and R1 was to have a planned follow up visit on 10/23/23.</p> <p>R1's behavior note dated 10/18/23 at 8:30 p.m., indicated R1 was self-transferring from a chair to hallway and yelling at one of the travel staff. Travel staff was encouraging R1 to sit down as her gait was unstable. Wheelchair was brought for R1 to sit down in, R1 appeared to have her arm raised to try and strike the travel nurse and was losing her balance. R1 was caught by the hips and eased into her wheelchair. R1 was yelling and screaming at the staff. At 9:00 p.m. R1's roommate had her call light on to go to bed, R1 was screaming and swinging at staff stating to the nurse that she is Russian and a communist, therefore incompetent. Intervention was to not engage with R1 any further and R1 was given Ativan.</p> <p>R1's behavioral progress note dated 10/19/23 at 6:00 a.m., indicated R1 was found walking around the room, staff got R1 to the bathroom and ready for the day and up in her chair. R1 was brought to desk and the next shift was getting report. R1 stated, "I don't have a nurse in my home, and I don't need a nurse and why are all these black people here? They should be where black people belong, but not here." R1 was told by aide to stop and what R1 was saying was not nice, R1 calmed down.</p> <p>R1's progress note dated 10/19/23 at 8:47 a.m., indicated R1 was very behavioral, refused snacks toileting etc "...Ativan given." At 10:08 a.m., Ativan was effective R1 was sleeping.</p>	F 626		

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F 626	<p>Continued From page 22</p> <p>R1's behavior progress note dated 10/19/23 at 12:20 p.m., indicated R1 was very behavioral at the start of the shift, constantly yelling about wanting to go back to America and does not appreciate the Russian invasion that is taking place. R1 called LPN-B, "Putin's right hand man" multiple times, R1 was very agitated. Additional note at 12:21 p.m., indicated R1 was very emotional at the beginning of the shift, yelling in the hallway refusing to be quiet when asked not to disturb other residents and was entering other resident's rooms. R1 was not easily redirected until occupational therapy (OT) came to work with R1.</p> <p>R1's behavior progress note, dated 10/19/23 at 4:45 p.m., indicated R1 was constantly up at the front desk asking for food and snacks even after already having been given some and was constantly asking for a phone call to FM-A after just talking to him, constantly self-transferring and walking in the hallway alone and was not easily redirected for long. R1 was given Ativan.</p> <p>R1's progress note dated 10/19/23 at 6:22 p.m., indicated a psychology eval and may see the in house counselor.</p> <p>R1's progress note dated 10/19/23 at 8:36 p.m., indicated R1 had been 1:1 with a hospitality aide, after the aide left R1, R1 had been attempting to walk without assist and when staff attempted to redirect R1 became agitated with staff. Medication was not effective. Additional note at 2:07 a.m., indicated R1 was in a pleasant mood with the 1:1 and after the aide left staff attempted to wash R1 up for the evening, but R1 refused. R1 was placed in bed and was up walking around</p>	F 626		

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F 626	<p>Continued From page 23</p> <p>in the room, when staff walked into R1's room, R1 put herself to bed. At 4:02 a.m. it was noted that R1 slept all night.</p> <p>R1's progress note dated 10/20/23 at 1:48 p.m., indicated R1 was yelling out about FM-A being incarcerated here. R1 refused toileting after expressing needing to use the restroom. R1 was given Ativan. At 4:25 p.m. Ativan administration was listed as effective.</p> <p>R1's behavior progress note dated 10/20/23 at 5:30 p.m., indicated R1 was eating in the dining room and was yelling, "I can't stand big nosed people! I'm tired of all these Chinese people!" R1 continually yelled out during supper about her anger towards workers of other races. Interventions attempted were empathetic communication, 1:1, essential oil therapy, massage, eating, change of location, offering toileting, asking about pain and pharmaceutical intervention, all listed as ineffective.</p> <p>R1's behavior progress note date 10/20/23 at 5:50 p.m., indicated R1 was grabbing items off the nursing desk looking for her cat's photo and stating staff were stealing from her. R1 was wheeling self down the hallway and going into other resident's rooms. R1 was verbally aggressive towards staff stating Hmong's don't belong in the kitchen. Interventions utilized were distraction, one on one, visual stimulation and a call to FM-A. The note did not list if these interventions were effective. At 6:00 p.m., R1 was seated at the nurses station verbalizing that other nationalities are not welcome here because they are not Americans. Intervention listed was one to one walking down the hall with wheelchair.</p>	F 626		

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F 626	<p>Continued From page 24</p> <p>R1's progress note dated 10/20/23 at 6:28 p.m., indicated R1 was agitated, aggressive towards staff members and had psychosis, the note indicated the on-call provider directed to send to the emergency department (ED) for behavior symptoms. The ED was called and facility staff were told they were full and would have to wait with R1. DON was notified and gave direction to call 911 for R1's transport.</p> <p>R1's progress note dated 10/20/23 at 6:18 p.m., indicated an ambulance and mayo clinic security were at the facility for escort. R1 was frustrated with the attempted assist onto the gurney yelling, "I am from Onalaska, I think there is a big conspiracy here going on." Security explained to R1 they are here to help her and R1 began crying, stated she doesn't know why FM-A would incarcerate her here and that her things are in the basement.</p> <p>R1's progress note dated 10/21/23 at 7:15 p.m., indicated staff had called security guard (SG)-A and was sitting with R1 by large TV. Licensed practical nurse (LPN)-A came down the hallway and R1 did seem a little calmer. R1 entered back into the hallway and began to yell at other residents and staff. LPN-A had placed a call to the on-call provider and agreed that R1 should go to the ED and be placed on 72-hour hold, as R1 had this type of behavior most of the day. LPN-A placed a call to the ED and talked with nurse practitioner (NP)-A from the ED. NP-A stated they could not place R1 on a hold if she did not meet the requirements. LPN-A then called the DON who stated to take R1 over to ER as R1 was a harm to herself and others. No bed hold was documented as being placed. R1 was then assisted to the ED with LPN-A and SG-A. R1 was</p>	F 626		

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F 626	<p>Continued From page 25 taken by stretcher to the ED at 7:18 p.m..</p> <p>R1's ED Note dated 10/20/23, indicated R1 was positive for behavioral problems and confusion, negative for agitation and delusions, R1 was not nervous or anxious and was not hyperactive. R1 was diagnosed with a urinary tract infection (UTI) and would be treated with antibiotics.</p> <p>R1's progress note dated 10/20/23 at 10:28 p.m., indicated R1 was returned from the ED via security. The note indicated R1 had been complaint and took her Zyprexa (antipsychotic medication). R1 had a probable UTI and was started on cefdinir (antibiotic) 300 mg daily for 10 days. At 11:49 p.m. R1 had been quiet and was resting in her room since the return from the ED.</p> <p>R1's progress note dated 10/21/23 at 5:53 a.m., indicated R1 had no behaviors during the shift.</p> <p>R1's behavior progress note dated 10/21/23 at 6:15 a.m., indicated R1 was seated at the nurse's station, when staff started coming in for work and R1 was making comments why we,"allow them people of color here." Redirection was unsuccessful and Ativan given. At 8:30 a.m. Ativan was listed effective.</p> <p>R1's behavior note dated 10/21/23 at 11:38 a.m., indicated that from 6:30 a.m. to 10:30 a.m., R1 was repeatedly standing up and walking around without staff or her wheelchair. R1 was assisted back into her wheelchair was easily redirected, snacks were given and staff talked about R1's cat.</p> <p>R1's behavior progress note dated 10/21/23 at 11:57 a.m., indicated R1 was screaming and</p>	F 626		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 626	<p>Continued From page 26</p> <p>waving her arms around at the desk stating she wanted to call FM-A and go home. Phone call attempted with no success. R1 grabbed the phone and tried calling but didn't know the number and refused to let staff have the phone. The nurse manager was called and notified of the situation and gave the order to have R1 sent to the ED again. The note indicated 911 was then called. Additionally, the facility called the ED for security to assist with R1 until EMS came and were notified that security was not in the building yet. No bed hold was signed at this time, the facility was notified this was the second ED visit and the charge nurse and on-call nurse manager were not comfortable taking R1 back until R1 was stabilized. At 12:20 p.m., R1 left for the ED with assist of police and emergency medical services (EMS). At 1:33 p.m. FM-A was notified of the above situation and requested a bed hold.</p> <p>R1's progress note dated 10/21/23 at 6:03 p.m., indicated the ED nurse called the facility and explained R1 was medically stable, and no hospitalization was required and the ED would be sending R1 back.</p> <p>R1's progress note dated 10/21/23 at 7:15 p.m., indicated LPN-C was called to where R1 was seated in her wheelchair in the common area, staff stated R1 was yelling, hitting out at them, and throwing things around the TV room. LPN-C called security. Security was sitting with R1 who then seemed calmer, when R1 entered the hallway, R1 would begin to yell at other residents and staff. LPN-C placed a call to the on-call provider who gave an order for a 72-hour hold. LPN-C called the ED and spoke with NP-A who told LPN-C they could not place a 72 hour hold as R1 did not meet the requirements. LPN-C called</p>	F 626		

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F 626	<p>Continued From page 27</p> <p>the DON who gave the order to take R1 to the ED as R1 was a threat to herself and others. No bed hold was placed.</p> <p>R1's progress note dated 10/22/23 at 8:16 a.m., indicated the DON spoke with the ED nurse to explain that R1 cannot come back today and will look into options on 10/23/23.</p> <p>During an interview on 11/1/23 at 3:56 p.m., FM-A indicated he was R1's power of attorney (POA). FM-A indicated he was not contacted about a bed hold when R1 was sent to the ED for the third time on 10/21/23. FM-A stated R1 had to live in the ED from 10/21/23 until 10/26/23 until there was a bed available at St Mary's hospital and that R1 was being treated for post stroke delirium. FM-A indicated he was not notified by the facility of ombudsman contact information, bed hold or any appeal process for R1's discharge.</p> <p>During an interview on 11/2/23 at 11:12 a.m., social worker (SW)-A indicated that R1 had a facility-initiated transfer to the emergency room (ER) on 10/21/23. SW-A indicated if the nurse is not able to get a bed hold, I would be the one to follow up on that. I would then have to reach out to the family, if we got a verbal, I would follow up with that to get a written bed hold. SW-A stated, "I did not follow up with [R1's] bed hold, on this because I was told we were not accepting [R1] back."</p> <p>During an interview on 11/2/23 at 11:24 a.m., NM-A indicated R1's behaviors included: R1 missed her cat and was fixated on it, wanting to know where her sons were, wanting to go home and making racial comments against staff. Interventions included to use redirection, assist</p>	F 626		

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F 626	<p>Continued From page 28</p> <p>with ADL's, distraction with food and movies and one to one. NM-A indicated there was nothing they were not able to provide for R1 related her care needs and behavioral needs. R1's behaviors escalated from 10/20/23 to 10/21/23 when she was sent to the ED three times within less than 24 hours. NM-A stated, the staff from the facility called me twice on 10/21/23 stating that R1 was yelling and uncontrollably crying that day, shouting at staff, insisting on calling family. R1 kept getting up, wouldn't sit down in her wheelchair and was a fall risk. R1 told staff that this place needed to be shut down, was not eating the food, stated you're drugging me and was also making racial comments. NM-A stated, "So, I told staff to send [R1] to the ER and we don't have the staff for behaviors like that."</p> <p>During an interview on 11/2/23 at 12:01 p.m., DON indicated R1 was here for short term rehab following a stroke. R1 did start to develop some behaviors that included missing her cats, wanting to know where her sons were, wanting to go home, and also made some racial comments. DON stated, "the son would not allow any medications to treat R1's behavior, how would we manage her behaviors?" DON indicated R1 was sent to the ED on 10/20/23 and was sent back with a UTI. DON indicated on 10/21/23 R1 was ramping up again and was sent back to the ED at 1:33 p.m. the ED sent R1 back again saying R1 was stable. DON stated, later that same evening I got a phone call that R1 was hitting staff and starting to swing out at residents. R1 was pushing her wheelchair, "we would tell her she needed to sit." The ED kept sending [R1] back with no medication management for R1's behaviors. DON indicated after R1 was sent for the third time. "I got a call from the NP at the ED,</p>	F 626		

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F 626	<p>Continued From page 29</p> <p>she told me what I was going to do, that I was going to accept R1 back, and that there was nothing wrong with R1 other than her having a UTI, NP was talking very rudely to me. I hung up on her and we did not accept [R1] back." DON indicated the facility does provide services for residents with diagnoses of dementia and strokes and residents who exhibit behaviors.</p> <p>During an interview on 11/2/23 at 4:08 p.m., emergency department (ED) NP-A via phone indicated R1 was sent to the ED on 10/21/23 around 8:30 p.m. from the nursing home. NP-A indicated the staff members from the nursing home were requesting a 72 hour hold for R1 due to behaviors and agitation. NP-A indicated R1 was assessed and did not meet the criteria for a 72 hour psychiatric hold. R1 was diagnosed with a UTI, and "was appropriate for discharge back to the facility, the staff refused to take R1 back essentially leaving R1 homeless." NP-A indicated R1 was in an altered state of mind, elderly, it was cold outside and we had to board R1 until we could find her proper placement.</p> <p>R1's medical record was reviewed and lacked evidence a written notice of the facility bed hold policy and/or procedure had been provided to R1/resident representative prior to being transferred to the ER and lacked evidence that the facility attempted to send or provide notice to R1 or R1's representative within 24 hours after being admitted. Additonally the medical record lacked documentation that R1's welfare or behaviors endangered the health and safety of individuals in the facility.</p> <p>Facility policy, "Transfer and Discharge from the Facility," revised April 2020, Residents and their</p>	F 626		

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F 626	<p>Continued From page 30</p> <p>representatives are involved in the discharge planning process. Ebenezer provides assistance and support to ensure a safe and appropriate plan for the resident. In cases where facility-initiated discharge or transfer is activated, the resident and their representative receive proper notice as required by law. 5. In cases of emergency transfer to the hospital, the Notice of Transfer or Therapeutic leave is given to the resident and the representative if they are present at the time of transfer. This information is documented in the resident record and sent along with the paperwork necessary for continuing care. If the representative is not present at the time of emergent transfer, the nursing staff contact the representative to notify them about the transfer, rationale, and location of transfer. At that time the nursing staff clarify the status of the bed hold and documents attempts to contact the resident representative and their response. On the first business day following the transfer, social service staff continue to attempt to reach the representative to clarify the status and obtain verbal clarification. Social Service documents Behold status in PCC and the Notice of Transfer or Therapeutic leave along with the bed hold notice is sent to the representative for signature and return. Document is scanned into PCC.</p> <p>Facility Assessment dated 7/13/23, identified that facility was able to take care of residents with a diagnosis of stroke and dementia and residents who exhibit behaviors.</p>	F 626		

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 11/1/23, 11/2/23 and 11/6/23, 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 order was issued. Please indicate in your electronic plan of correction you have</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/22/23
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2 000	<p>Continued From page 1</p> <p>reviewed these orders and identify the date when they will be completed.</p> <p>The following complaints were reviewed.</p> <p>H52186667C (MN97931 and MN97974) H52187006C (MN98329) with a licensing order issued at 0340 and 1825.</p> <p>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.</p> <p>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></p> <p>The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior</p>	2 000		

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2 000	Continued From page 2 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		
2 340	MN Rule 4658.0135 Subp. 1,2 Policy Records Subpart 1. Availability of policies. All policies and procedures directly related to resident care adopted by the home must be placed on file and be made available upon request to nursing home personnel, residents, legal representatives, and designated representatives. Subp. 2. Admission policies. Admission policies must be made available upon request to prospective residents, family members, legal representatives, and designated representatives. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to readmit a resident (R1) to return to the facility after a transfer to the attached hospital emergency department (ED) for an increase in R1's behaviors for the third time in less than 24 hours. The facility would not allow R1 to return to the facility even though R1 was deemed medically stable, and the facility was able to meet the needs of the resident as identified by their facility assessment.	2 340	CORRECTED	11/27/23

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2 340	<p>Continued From page 3</p> <p>Findings include:</p> <p>R1's after visit summary (AVS), dated 10/10/23, indicated on 9/26/23 R1 was admitted for a stroke and presented with altered mental status. During the hospital course on 9/27/23, R1 pulled out her nasogastric (NG) tube, restraints were placed and R1 improved but struggled with following and understanding commands. On 9/29/23, R1 had goal directed questions, but was paranoid. R1 had intravenous (IV) contrast and poor oral intake resulting in acute on chronic kidney disease. R1 had two unresponsive episodes with an incontinent bowel movement thought to be vasovagal (sudden drop-in heart rate in pulse leading to loss of consciousness). R1's cognition indicated poor safety awareness, poor attention/concentration, short term memory loss and impulsivity. Further the AVS indicated R1 required daily inpatient skilled nursing and rehabilitation services.</p> <p>R1's admission, Minimum Data Set (MDS), dated 10/16/23, indicated R1's cognition was moderately impaired and had diagnoses to include stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further indicated R1 to have delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's admission assessment dated 10/10/23, indicated R1 had mild left sided weakness, required extensive assist of one person with transfers, dressing and personal hygiene, needed total dependence of one staff with toileting and no mobility device used. R1 was alert and oriented to person, displayed confusion, restlessness, impulsivity and unsafe decision-making due to cognitive impairment.</p>	2 340		

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2 340	<p>Continued From page 4</p> <p>R1's care plan dated 10/16/23 indicated Mood/behavior: I have potential for changes in my mood related to admission to care center, new stroke, impaired cognition. I at times will refuse cares that are offered by staff, I am continuing to adjust to placement at CC. I often am unable to carry on conversation due to being easily distracted and impaired thought processes. I often speak about my sons whom I lived with prior. My behaviors have escalated since my admission. I have had episodes of elevated agitation, inability to focus, insomnia, verbal threats, paranoia, and disruptive behaviors involving other residents. I am also making frequent racial remarks and slurs towards staff that are African American heritage. Interventions included to: 10/16/23, administer medications as ordered, observe for signs and symptoms of mania or hypomania, racing thoughts or euphoria, increased irritability, frequent mood changes, pressure speech, flight of ideas, marked change in need for sleep, agitation, or hyperactivity and monitor/record/report to MD mood patterns s/sx of depression, anxiety, sad mood as per facility behavioral monitoring protocols. On 10/18/23, attempt nonpharmacological interventions, to ask me about my cat and offer me a snack or beverage. On 10/19/23 to call 911 if physically aggressive behavior and inability to redirect behaviors of attempted elopement.</p> <p>R1's progress note dated 10/13/23 at 10:03 p.m., indicated R1 was assisted to bed and stated, "I do want to apologize because I just don't like asking for help." R1 became teary eyed and stated, "I just miss my cat." Licensed practical nurse (LPN)-A sat with R1 to let R1 express her feelings and spoke about her cat. R1 appeared to be in better spirits.</p>	2 340		

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2 340	<p>Continued From page 5</p> <p>R1's behavior progress note dated 10/15/23 at 6:39 a.m., indicated registered nurse (RN)-A overheard an aide asking for assist in R1's room. R1 was seated at the edge of her bed ready to transfer to wheelchair and was being resistive stating the media is influencing the facility and R1 was looking for her cat. R1 was not willing to lay down or get in her wheelchair. R1 stated she would yell if staff did not leave her alone.</p> <p>R1's behavior progress note dated 10/15/23 at 6:33 p.m., indicated R1 was wandering into other resident rooms looking for her room, R1 was redirected. The progress note did not identify if this was effective.</p> <p>R1's progress note dated 10/16/23 at 6:12 a.m., indicated R1 self-transferred to the bathroom and R1 transferred to her wheelchair and was brought out by the nurses station.</p> <p>R1's behavior progress note, dated 10/16/23 at 8:38 a.m., indicated staff handed out R1's breakfast tray, R1 hollered at staff, "I don't want that. I have a hat and you are from a poor country. I hate poor countries so that means I hate you." R1 continued to holler at staff until LPN-B came in and asked staff to leave the room. LPN-B took R1's tray as R1 refused to eat. Redirection was attempted and not effective, so staff left the room.</p> <p>R1's behavioral progress note, dated 10/16/23 at 9:00 a.m., indicated R1 was self-transferring and walking around the unit independently refusing to let the aides help her because, "they're from a different country and holding me here against my will. They are invading me here and I'm from the united states of America." R1 was worked up and tried to enter an other resident's rooms</p>	2 340		
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2 340	<p>Continued From page 6</p> <p>screaming at LPN-B that R1 owned them, and she could go in them. R1 was yelling about wanting her cat and wanting to save her cat from the invasion that's taking place. Interventions listed were redirection, reapproach, food and warm blanket that were indicated as ineffective. R1 asked to go for a walk and agreed to lay in bed which was listed as effective.</p> <p>R1's behavior progress note dated 10/16/23 at 1:53 p.m., indicated R1 was walking around the hall without assist hollering at staff how they are keeping her here, redirection was attempted and was ineffective.</p> <p>R1's behavior progress note dated 10/16/23 at 2:04 p.m., indicated R1 was using the bathroom and was shouting and hollering making remarks to staff, throwing her sweater at staff, and raising her hand to staff. Redirection was attempted and listed as ineffective.</p> <p>R1's progress note dated 10/16/23 at 8:53 p.m., indicated R1 was very hard to redirect during the shift. R1 wandered into other resident rooms, upon redirection R1 would yell at staff and call them names. R1 would self transfer and yell at staff if they tried to walk with R1 or get R1 back in the wheelchair. R1 often did not make sense, often yelling about her cat. After listening to staff concerns about risk of falling R1 transferred to her wheelchair and was brought up to the nurse's station.</p> <p>R1's behavior progress note dated 10/17/23 at 12:30 a.m., indicated R1 was going through her roommate's closet, trying on roommate's clothes and walking around her room alone. Intervention: redirected and educated on touching others personal items, was able to be redirected back to</p>	2 340		
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2 340	<p>Continued From page 7</p> <p>bed.</p> <p>R1's behavior progress note dated 10/17/23 at 8:06 a.m., indicated R1 was lying in bed sideways with her pad and pants pulled down with her legs on her roommate's bed and had roommate's garbage can as a pillow. LPN-C attempted to redirect R1 to her own bed and R1 called LPN-C "stupid", and that LPN-C is only here to "make her life hell", not helping her. LPN-C left the room once R1 went to her own bed.</p> <p>R1's nurse practitioner provider note, dated 10/17/23, indicated R1 to be confused and very pleasant. Reported of yelling and swinging at staff while trying to help R1 get her clothes rearranged. Therapy indicated R1 can't focus on a single task, was difficult to redirect and struggled with sleep. The note indicated a new order to restart melatonin (sleep supplement), start mirtazapine (antidepressant) 7.5 milligrams (mg) at HS (hour of sleep) and Seroquel (antipsychotic medication) 12.5 mg was considered for agitation but family member (FM)-A was not in agreement.</p> <p>R1's progress note dated 10/17/23 at 4:30 p.m., indicated R1 was given Seroquel, a subsequent note at 8:00 p.m. indicated the medication was ineffective.</p> <p>R1's behavior progress note dated 10/18/23 at 1:20 p.m., indicated R1 was seated in the common area and began yelling at the TV and a staff member attempted to console R1 but it led to R1 yelling more. R1 was given space and R1 was moved to a different chair. A staff member went to go get a warm blanket and R1 was no longer in the chair. R1 was found at the physical</p>	2 340		

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2 340	<p>Continued From page 8</p> <p>therapy (PT) desk yelling about the facility, the food, and stated she would report them all to the state. Intervention was to have a 1:1 and during this time and R1 stated, "the Mexican and the black people here are ruining our country," and made a remark about employees here of color are going to "strap bombs on their chest." Interventions attempted were empathetic listening, calm therapeutic communication, and redirection of conversation. A hospitality aide sat with R1 and massaged lavender lotion on her hands which was effective at times before R1 became worked up again. R1 was seeing a provider at 1:30 p.m.</p> <p>R1's provider note dated 10/18/23, indicated R1 had entered the therapy office and refused to leave, stating that cars were being sold right from the nursing home parking lot. R1 had escalating anxiety and agitation following R1's admission to the facility following a hospital stay from stroke, was started on mirtazapine 10/17/23 as well as melatonin. The note indicated Seroquel was discussed with family member (FM)-A and was declined. R1 was focused on her car during the visit, stating her Jeep was sold from the parking lot. Additionally, the note indicated to follow up with FM-A and FM-A agreed there was increased agitation within the last day, and R1 had been in distress with these worries. FM-A noted R1 had gotten into very specific news stories in the past and would get worked up on some topics and would be difficult for R1 to break that focus. The provider noted a black box warning with Seroquel, so would not pursue. The note indicated to start Ativan (antianxiety medication) 0.5 mg and R1 was to have a planned follow up visit on 10/23/23.</p> <p>R1's behavior note dated 10/18/23 at 8:30 p.m., indicated R1 was self-transferring from a chair to</p>	2 340		

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2 340	<p>Continued From page 9</p> <p>hallway and yelling at one of the travel staff. Travel staff was encouraging R1 to sit down as her gait was unstable. Wheelchair was brought for R1 to sit down in, R1 appeared to have her arm raised to try and strike the travel nurse and was losing her balance. R1 was caught by the hips and eased into her wheelchair. R1 was yelling and screaming at the staff. At 9:00 p.m. R1's roommate had her call light on to go to bed, R1 was screaming and swinging at staff stating to the nurse that she is Russian and a communist, therefore incompetent. Intervention was to not engage with R1 any further and R1 was given Ativan.</p> <p>R1's behavioral progress note dated 10/19/23 at 6:00 a.m., indicated R1 was found walking around the room, staff got R1 to the bathroom and ready for the day and up in her chair. R1 was brought to desk and the next shift was getting report. R1 stated, "I don't have a nurse in my home, and I don't need a nurse and why are all these black people here? They should be where black people belong, but not here." R1 was told by aide to stop and what R1 was saying was not nice, R1 calmed down.</p> <p>R1's progress note dated 10/19/23 at 8:47 a.m., indicated R1 was very behavioral, refused snacks toileting etc "...Ativan given." At 10:08 a.m., Ativan was effective R1 was sleeping.</p> <p>R1's behavior progress note dated 10/19/23 at 12:20 p.m., indicated R1 was very behavioral at the start of the shift, constantly yelling about wanting to go back to America and does not appreciate the Russian invasion that is taking place. R1 called LPN-B, "Putin's right hand man" multiple times, R1 was very agitated. Additional note at 12:21 p.m., indicated R1 was very</p>	2 340		
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2 340	<p>Continued From page 10</p> <p>emotional at the beginning of the shift, yelling in the hallway refusing to be quiet when asked not to disturb other residents and was entering other resident's rooms. R1 was not easily redirected until occupational therapy (OT) came to work with R1.</p> <p>R1's behavior progress note, dated 10/19/23 at 4:45 p.m., indicated R1 was constantly up at the front desk asking for food and snacks even after already having been given some and was constantly asking for a phone call to FM-A after just talking to him, constantly self-transferring and walking in the hallway alone and was not easily redirected for long. R1 was given Ativan.</p> <p>R1's progress note dated 10/19/23 at 6:22 p.m., indicated a psychology eval and may see the in house counselor.</p> <p>R1's progress note dated 10/19/23 at 8:36 p.m., indicated R1 had been 1:1 with a hospitality aide, after the aide left R1, R1 had been attempting to walk without assist and when staff attempted to redirect R1 became agitated with staff. Medication was not effective. Additional note at 2:07 a.m., indicated R1 was in a pleasant mood with the 1:1 and after the aide left staff attempted to wash R1 up for the evening, but R1 refused. R1 was placed in bed and was up walking around in the room, when staff walked into R1's room, R1 put herself to bed. At 4:02 a.m. it was noted that R1 slept all night.</p> <p>R1's progress note dated 10/20/23 at 1:48 p.m., indicated R1 was yelling out about FM-A being incarcerated here. R1 refused toileting after expressing needing to use the restroom. R1 was given Ativan. At 4:25 p.m. Ativan administration was listed as effective.</p>	2 340		

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2 340	<p>Continued From page 11</p> <p>R1's behavior progress note dated 10/20/23 at 5:30 p.m., indicated R1 was eating in the dining room and was yelling, "I can't stand big nosed people! I'm tired of all these Chinese people!" R1 continually yelled out during supper about her anger towards workers of other races. Interventions attempted were empathetic communication, 1:1, essential oil therapy, massage, eating, change of location, offering toileting, asking about pain and pharmaceutical intervention, all listed as ineffective.</p> <p>R1's behavior progress note date 10/20/23 at 5:50 p.m., indicated R1 was grabbing items off the nursing desk looking for her cat's photo and stating staff were stealing from her. R1 was wheeling self down the hallway and going into other resident's rooms. R1 was verbally aggressive towards staff stating Hmong's don't belong in the kitchen. Interventions utilized were distraction, one on one, visual stimulation and a call to FM-A. The note did not list if these interventions were effective. At 6:00 p.m., R1 was seated at the nurses station verbalizing that other nationalities are not welcome here because they are not Americans. Intervention listed was one to one walking down the hall with wheelchair.</p> <p>R1's progress note dated 10/20/23 at 6:28 p.m., indicated R1 was agitated, aggressive towards staff members and had psychosis, the note indicated the on-call provider directed to send to the emergency department (ED) for behavior symptoms. The ED was called and facility staff were told they were full and would have to wait with R1. DON was notified and gave direction to call 911 for R1's transport.</p> <p>R1's progress note dated 10/20/23 at 6:18 p.m.,</p>	2 340		

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2 340	<p>Continued From page 12</p> <p>indicated an ambulance and mayo clinic security were at the facility for escort. R1 was frustrated with the attempted assist onto the gurney yelling, "I am from Onalaska, I think there is a big conspiracy here going on." Security explained to R1 they are here to help her and R1 began crying, stated she doesn't know why FM-A would incarcerate her here and that her things are in the basement.</p> <p>R1's progress note dated 10/21/23 at 7:15 p.m., indicated staff had called security guard (SG)-A and was sitting with R1 by large TV. Licensed practical nurse (LPN)-A came down the hallway and R1 did seem a little calmer. R1 entered back into the hallway and began to yell at other residents and staff. LPN-A had placed a call to the on-call provider and agreed that R1 should go to the ED and be placed on 72-hour hold, as R1 had this type of behavior most of the day. LPN-A placed a call to the ED and talked with nurse practitioner (NP)-A from the ED. NP-A stated they could not place R1 on a hold if she did not meet the requirements. LPN-A then called the DON who stated to take R1 over to ER as R1 was a harm to herself and others. No bed hold was documented as being placed. R1 was then assisted to the ED with LPN-A and SG-A. R1 was taken by stretcher to the ED at 7:18 p.m..</p> <p>R1's ED Note dated 10/20/23, indicated R1 was positive for behavioral problems and confusion, negative for agitation and delusions, R1 was not nervous or anxious and was not hyperactive. R1 was diagnosed with a urinary tract infection (UTI) and would be treated with antibiotics.</p> <p>R1's progress note dated 10/20/23 at 10:28 p.m., indicated R1 was returned from the ED via security. The note indicated R1 had been</p>	2 340		

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2 340	<p>Continued From page 13</p> <p>complaint and took her Zyprexa (antipsychotic medication). R1 had a probable UTI and was started on cefdinir (antibiotic) 300 mg daily for 10 days. At 11:49 p.m. R1 had been quiet and was resting in her room since the return from the ED.</p> <p>R1's progress note dated 10/21/23 at 5:53 a.m., indicated R1 had no behaviors during the shift.</p> <p>R1's behavior progress note dated 10/21/23 at 6:15 a.m., indicated R1 was seated at the nurse's station, when staff started coming in for work and R1 was making comments why we,"allow them people of color here." Redirection was unsuccessful and Ativan given. At 8:30 a.m. Ativan was listed effective.</p> <p>R1's behavior note dated 10/21/23 at 11:38 a.m., indicated that from 6:30 a.m. to 10:30 a.m., R1 was repeatedly standing up and walking around without staff or her wheelchair. R1 was assisted back into her wheelchair was easily redirected, snacks were given and staff talked about R1's cat.</p> <p>R1's behavior progress note dated 10/21/23 at 11:57 a.m., indicated R1 was screaming and waving her arms around at the desk stating she wanted to call FM-A and go home. Phone call attempted with no success. R1 grabbed the phone and tried calling but didn't know the number and refused to let staff have the phone. The nurse manager was called and notified of the situation and gave the order to have R1 sent to the ED again. The note indicated 911 was then called. Additionally, the facility called the ED for security to assist with R1 until EMS came and were notified that security was not in the building yet. No bed hold was signed at this time, the facility was notified this was the second ED visit</p>	2 340		

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2 340	<p>Continued From page 14</p> <p>and the charge nurse and on-call nurse manager were not comfortable taking R1 back until R1 was stabilized. At 12:20 p.m., R1 left for the ED with assist of police and emergency medical services (EMS). At 1:33 p.m. FM-A was notified of the above situation and requested a bed hold.</p> <p>R1's progress note dated 10/21/23 at 6:03 p.m., indicated the ED nurse called the facility and explained R1 was medically stable, and no hospitalization was required and the ED would be sending R1 back.</p> <p>R1's progress note dated 10/21/23 at 7:15 p.m., indicated LPN-C was called to where R1 was seated in her wheelchair in the common area, staff stated R1 was yelling, hitting out at them, and throwing things around the TV room. LPN-C called security. Security was sitting with R1 who then seemed calmer, when R1 entered the hallway, R1 would begin to yell at other residents and staff. LPN-C placed a call to the on-call provider who gave an order for a 72-hour hold. LPN-C called the ED and spoke with NP-A who told LPN-C they could not place a 72 hour hold as R1 did not meet the requirements. LPN-C called the DON who gave the order to take R1 to the ED as R1 was a threat to herself and others. No bed hold was placed.</p> <p>R1's progress note dated 10/22/23 at 8:16 a.m., indicated the DON spoke with the ED nurse to explain that R1 cannot come back today and will look into options on 10/23/23.</p> <p>During an interview on 11/1/23 at 3:56 p.m., FM-A indicated he was R1's power of attorney (POA). FM-A indicated he was not contacted about a bed hold when R1 was sent to the ED for the third time on 10/21/23. FM-A stated R1 had to live in</p>	2 340		
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2 340	<p>Continued From page 15</p> <p>the ED from 10/21/23 until 10/26/23 until there was a bed available at St Mary's hospital and that R1 was being treated for post stroke delirium. FM-A indicated he was not notified by the facility of ombudsman contact information, bed hold or any appeal process for R1's discharge.</p> <p>During an interview on 11/2/23 at 11:12 a.m., social worker (SW)-A indicated that R1 had a facility-initiated transfer to the emergency room (ER) on 10/21/23. SW-A indicated if the nurse is not able to get a bed hold, I would be the one to follow up on that. I would then have to reach out to the family, if we got a verbal, I would follow up with that to get a written bed hold. SW-A stated, "I did not follow up with [R1's] bed hold, on this because I was told we were not accepting [R1] back."</p> <p>During an interview on 11/2/23 at 11:24 a.m., NM-A indicated R1's behaviors included: R1 missed her cat and was fixated on it, wanting to know where her sons were, wanting to go home and making racial comments against staff. Interventions included to use redirection, assist with ADL's, distraction with food and movies and one to one. NM-A indicated there was nothing they were not able to provide for R1 related her care needs and behavioral needs. R1's behaviors escalated from 10/20/23 to 10/21/23 when she was sent to the ED three times within less than 24 hours. NM-A stated, the staff from the facility called me twice on 10/21/23 stating that R1 was yelling and uncontrollably crying that day, shouting at staff, insisting on calling family. R1 kept getting up, wouldn't sit down in her wheelchair and was a fall risk. R1 told staff that this place needed to be shut down, was not eating the food, stated you're drugging me and was also making racial comments. NM-A stated,</p>	2 340		
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2 340	<p>Continued From page 16</p> <p>"So, I told staff to send [R1] to the ER and we don't have the staff for behaviors like that."</p> <p>During an interview on 11/2/23 at 12:01 p.m., DON indicated R1 was here for short term rehab following a stroke. R1 did start to develop some behaviors that included missing her cats, wanting to know where her sons were, wanting to go home, and also made some racial comments. DON stated, "the son would not allow any medications to treat R1's behavior, how would we manage her behaviors?" DON indicated R1 was sent to the ED on 10/20/23 and was sent back with a UTI. DON indicated on 10/21/23 R1 was ramping up again and was sent back to the ED at 1:33 p.m. the ED sent R1 back again saying R1 was stable. DON stated, later that same evening I got a phone call that R1 was hitting staff and starting to swing out at residents. R1 was pushing her wheelchair, "we would tell her she needed to sit." The ED kept sending [R1] back with no medication management for R1's behaviors. DON indicated after R1 was sent for the third time. "I got a call from the NP at the ED, she told me what I was going to do, that I was going to accept R1 back, and that there was nothing wrong with R1 other than her having a UTI, NP was talking very rudely to me. I hung up on her and we did not accept [R1] back." DON indicated the facility does provide services for residents with diagnoses of dementia and strokes and residents who exhibit behaviors.</p> <p>During an interview on 11/2/23 at 4:08 p.m., emergency department (ED) NP-A via phone indicated R1 was sent to the ED on 10/21/23 around 8:30 p.m. from the nursing home. NP-A indicated the staff members from the nursing home were requesting a 72 hour hold for R1 due to behaviors and agitation. NP-A indicated R1</p>	2 340		

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2 340	<p>Continued From page 17</p> <p>was assessed and did not meet the criteria for a 72 hour psychiatric hold. R1 was diagnosed with a UTI, and "was appropriate for discharge back to the facility, the staff refused to take R1 back essentially leaving R1 homeless." NP-A indicated R1 was in an altered state of mind, elderly, it was cold outside and we had to board R1 until we could find her proper placement.</p> <p>R1's medical record was reviewed and lacked evidence a written notice of the facility bed hold policy and/or procedure had been provided to R1/resident representative prior to being transferred to the ER and lacked evidence that the facility attempted to send or provide notice to R1 or R1's representative within 24 hours after being admitted. Additionally the medical record lacked documentation that R1's welfare or behaviors endangered the health and safety of individuals in the facility.</p> <p>Facility policy, "Transfer and Discharge from the Facility," revised April 2020, Residents and their representatives are involved in the discharge planning process. Ebenezer provides assistance and support to ensure a safe and appropriate plan for the resident. In cases where facility-initiated discharge or transfer is activated, the resident and their representative receive proper notice as required by law. 5. In cases of emergency transfer to the hospital, the Notice of Transfer or Therapeutic leave is given to the resident and the representative if they are present at the time of transfer. This information is documented in the resident record and sent along with the paperwork necessary for continuing care. If the representative is not present at the time of emergent transfer, the nursing staff contact the representative to notify them about the transfer, rationale, and location of transfer. At that time</p>	2 340		

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2 340	<p>Continued From page 18</p> <p>the nursing staff clarify the status of the bed hold and documents attempts to contact the resident representative and their response. On the first business day following the transfer, social service staff continue to attempt to reach the representative to clarify the status and obtain verbal clarification. Social Service documents Behold status in PCC and the Notice of Transfer or Therapeutic leave along with the bed hold notice is sent to the representative for signature and return. Document is scanned into PCC.</p> <p>Facility Assessment dated 7/13/23, identified that facility was able to take care of residents with a diagnosis of stroke and dementia and residents who exhibit behaviors.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents who have facility initiated discharges are able to return to the facility if residents are medically stable for the facility to provide services to them. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) that are sent to the ER are permitted to return. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days</p>	2 340		
21825	<p>MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights</p> <p>Subd. 9. Information about treatment.</p>	21825		11/27/23

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21825	<p>Continued From page 19</p> <p>Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information.</p> <p>Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to obtain informed consent for a psychotropic medication (medication that affects behavior, mood thought or perception) for 1 of 1 residents (R1) reviewed for neglect in relation to medications.</p>	21825	CORRECTED	

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21825	<p>Continued From page 20</p> <p>Findings include:</p> <p>R1's admission, Minimum Data Set (MDS), dated 10/16/23, indicated R1's cognition was moderately impaired. R1's diagnoses included stroke, hemiplegia (paralysis on one side of body), diabetes and stage four kidney disease. Further the MDS indicated R1 to had delusions, physical, verbal, and other behaviors for one to three days.</p> <p>R1's nurse practioner provider note dated 10/17/23, indicated R1 to be confused and very pleasant. Reported of yelling and swinging at staff while trying to help R1 get her clothes rearranged. Therapy indicated R1 can't focus on a single task with difficulty to redirect and had struggles with sleep. The note indicated a new order to restart melatonin (sleep supplement), start mirtazapine (antidepressant) 7.5 milligrams (mg) at HS (hour of sleep) and Seroquel (antipsychotic medication) 12.5 mg was considered for agitation but family member (FM)-A was not in agreement.</p> <p>R1's medical record lacked informed consent for the use of psychotropic medications.</p> <p>R1's medication administration record (MAR), dated October of 2023, indicated R3 received Seroquel 12.5 mg on 10/17/23 at 4:30 p.m.</p> <p>R1's physician provider note dated 10/18/23 indicated R1 had entered the therapy office and refused to leave, stating that cars were being sold right from the nursing home parking lot, had escalating anxiety and agitation following R1's admission to the facility following a hospital stay from stroke, was started on mirtazapine 10/17/23</p>	21825		
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21825	<p>Continued From page 21</p> <p>as well as melatonin. The note indicated Seroquel was discussed with FM-A and was declined. R1 was focused on her car during the visit, stating her jeep was sold from the parking lot. Additionally the not indicated follow up with FM-A and FM-A agreed there was increased agitation within the last day, and R1 had been in distress with these worries. FM-A noted R1 had gotten very into specific news stories in the past and would get worked up on some topics and would be difficult for R1 to break that focus. The provider noted a black box warning with Seroquel, so would not pursue, will start Ativan (antianxiety medication) 0.5 mg and R1 had a planned follow up on 10/23/23.</p> <p>During an interview on 11/1/23 at 3:56 p.m. FM-A stated someone at the facility called on 10/18/23 and was told R1 locked herself in the therapy office so the facility gave R1 some Seroquel. I got a call from the nurse practioner (NP)-A on 10/17/23 about R1 starting Seroquel and I told her no. FM-A stated R1 had stage four kidney disease and Seroquel is not good for the kidney function.</p> <p>During an interview on 11/2/23 at 12:01 p.m., director of nursing (DON) stated R1 was prescribed Seroquel on 10/17/23 and it was given that day without an informed consent in place. DON indicated an informed consent must be obtained prior to administering any antipsychotic.</p> <p>Facility policy, "Psychopharmacological Drug Use," reviewed 10/6/22, indicated residents are free from the use of any psychotropic medication for purposes of discipline or convenience and from medications not required to treat medical symptoms. 1. Psychopharmacologic drugs include antianxiety agents, antidepressants,</p>	21825		
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21825	<p>Continued From page 22</p> <p>sedatives, hypnotics, antipsychotic's, and "other" drugs that affect behavior ... 4. The resident or his/ her representative will be provided information regarding the need for, the desired effects and the potential unwanted side effects of the medication. This enables the resident or his/ her representative to make an informed decision regarding the use of psychoactive medication. 5. Informed consent for psychoactive medication will be obtained from the resident or legal representative for medications used to alter behavior. 6. Consent will be obtained as verbal/ telephone consent or a written signed consent.</p> <p>SUGGESTED METHOD OF CORRECTION: Director of nursing (DON) and/or their designee could develop/revise policies for resident choices concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. DON or designee could educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed, then audiit to ensure compliance.</p>	21825		

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21825	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		