Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 14, 2023

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

RE: CCN: 245222
Cycle Start Date: May 31, 2023

Dear Administrator:

On July 12, 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.

Please contact me with any questions regarding this letter.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2023

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

Re: Reinspection Results
Event ID: IQJP12

Dear Administrator:

On July 12, 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 May 31, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 9, 2023

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

RE: CCN: 245222
Cycle Start Date: May 31, 2023

Dear Administrator:

On May 31, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 August 31, 2023, (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 December 1, 2023, (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.

Sincerely,

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

Electronically delivered

June 9, 2023

Administrator
The Estates At Chateau LLC
2106 Second Avenue South
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders
Event ID: IQJP11

Dear Administrator:

The above facility was surveyed on May 31, 2023, through May 31, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. BUILDING _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/31/23, 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. The following complaint was reviewed: H52222412C (MN93918) with a deficiency issued at F690 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		6/30/23

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

Electronically Signed | 06/19/2023

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 690	Continued From page 1 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 residents (R1, R2, R3) reviewed for catheter use received appropriate physician orders for ongoing catheter care, a comprehensive care plan for indwelling catheters, and adequate catheter care documentation. R1's Diagnoses List printed 5/31/23, indicated T1's diagnoses included malignant neoplasm of bladder (bladder cancer) and hydronephrosis with renal and ureteral calculous obstruction (a blockage in the tube from the kidney to the bladder).	F 690	Immediate Corrective Action:¿¿¿ R1, R2, R3 had orders entered regarding their catheter/ostomy including: catheter type, size, balloon and how often it is to be changed, catheter care, site care. The care plan was reviewed and revised to reflect this information. All residents with catheters and urostomy had the site assessed and were assessed for s/sx of UTI. No concerns were observed. Staff onsite at time of findings were	

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F 690	Continued From page 2 R1's admission Minimum Data Sheet (MDS) dated 4/4/23, indicated R1 was cognitively intact, and had an indwelling catheter. R1's Care Area Assessment (CAA) DATE HERE indicated R1 had a nephrostomy tube (a tube placed through the skin of the lower back into the kidney for urine excretion) related to a diagnosis of right hydronephrosis (excess accumulation of urine in the kidney that causes swelling). The CAA further indicated to care plan to maintain current level of function. R1's hospital transfer information dated 3/28/23, indicated R1's right percutaneous nephrostomy tube was placed on 1/12/23. R1's Physician's Orders printed 5/31/23, lacked orders for the care of the nephrostomy tube. R1's care plan dated 3/29/23, lacked direction for nephrostomy tube care. R2's Diagnoses List printed 5/31/23, included urethritis (inflammation of the tube carrying urine from the bladder to the outside of the body), retention of urine, and anoxic brain damage (caused by complete lack of oxygen to the brain). R2's significant change MDS dated 4/12/23, indicated R1 was cognitively intact and had an indwelling catheter. R2's Provider Order dated 2/16/23, indicated Foley catheter (a tube that passes through the urethra into the bladder to drain urine) for urinary retention, and an order dated 2/20/23, indicated	F 690	educated regarding catheter care procedure and standing orders¿ Nursing leadership staff were re-educated at time of findings on catheter orders, care planning and assessments.¿ Action as it applies to others:¿¿¿ Procedure for catheter care (indwelling and suprapubic) reviewed ¿ All nursing staff will be educated further regarding catheter care procedures, including reviewing orders, catheter care, site care, recording output. Also educated regarding importance of reviewing paperwork when residents return from appointments to ensure all new orders are identified. – education was started immediately and continues until all nursing staff have completed. ¿ All nursing staff will complete a new competency for catheter care¿ A full house audit of residents with catheters was completed, identified and corrected orders and care plan items that were found.¿ Full house audit of residents with appointments completed to ensure after visit summary is reviewed and uploaded to PCC and to ensure all orders are correctly transcribed. ¿ Education with nursing leadership	

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F 690	Continued From page 3 monitor catheter output every shift. R2 lacked orders for a suprapubic (SP) catheter, and orders for the catheter size, insertion site cleaning, and dressing changes. R2's Urology provider note dated 3/10/23, indicated required an 18 French (FR) Foley catheter, and R1 should return to the clinic for catheter follow-up in 4-6 weeks. The medical record lacked indication R2 returned to the clinic in 4-6 weeks. R2's hospital discharge note dated 5/1/23, indicated R2 was seen at the Interventional Radiology Clinic for suprapubic catheter placement and to schedule a catheter exchange 4-6 weeks afterwards. R2's May 2023 Treatment Administration Record indicated from May 15 to May 30, 2023, the urinary output was not recorded as ordered 10 of 30 shifts. R3's Diagnoses List printed 5/31/23, included a spinal injury in the thoracic region, neuromuscular dysfunction of the bladder, and paraplegia. R3's quarterly MDS dated 3/2/23, indicated R3 was cognitively intact and had an indwelling catheter. R3's Physician's Orders printed 5/31/23, lacked orders for catheter size and catheter site care. R3's care plan dated 7/26/21, indicated monitor Foley catheter output, change Foley catheter per policy, and provide catheter care per policy. R3's progress notes dated 5/13/23, and 5/28/23,	F 690	regarding assessment and care planning will be held on June 23 Recurrence will be prevented by:¿¿ Will continue to audit catheter orders/care plan¿twice weekly for 6 weeks ¿ Will review in stand-up new admission/re-admission to ensure all appropriate orders are in place¿regarding catheters Will to continue to audit appointments along with after visit summaries twice weekly for 6 weeks¿ Will audit outputs to ensure they are being recorded twice weekly for 6 weeks Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits¿ The Correction will be Monitored by:¿¿Director of Nursing or Designee ¿	

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F 690	Continued From page 4 indicated R3 was continent of bladder with no mention of a catheter. R3's medical record lacked documentation the catheter insertion site was cleaned. On 5/31/23 at 12:01 p.m., during observation, R1 had a split sponge dressing around the SP catheter at the insertion site next to his skin of his lower abdomen. During interview, R1 stated the dressing was changed, "About every other day but not every day." On 5/31/23 at 12:10 p.m., licensed practical nurse (LPN)-A stated the care plan for a resident with a SP catheter should include monitor fluid intake and urine output (I/O). LPN-A also stated the R2's care plan should have indicated the type of catheter R2 used, and should have indicated an SP catheter, not a Foley catheter. On 05/31/23 at 12:10 p.m., R3 stated catheter care is "not up to par." R3 explained he has to remind staff to clean the area around the catheter, and to empty the catheter drainage bag. R3 stated he notifies staff when his catheter needs changing, as he can feel when it starts to "back up." On 5/31/23 at 12:18 p.m., registered nurse (RN)-A stated there should be orders to change the catheter as needed, clean the catheter site, and record catheter output. The size of the catheter will be in the resident's physician orders or in the hospital paperwork. RN-A acknowledged R3's physician orders did not contain catheter size or catheter site care. RN-A stated she would contact the physician to obtain catheter size if there was no order stating size. RN-A further	F 690		

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F 690	Continued From page 5 stated physician orders should include what kind of catheter a resident has, and specific instructions on how to take care of it. On 5/31/23 at 12:19 p.m., LPN-B acknowledged R2 lacked orders for SP catheter care including dressing changes around the SP catheter insertion site. LPN-B acknowledged R2 had orders for a Foley catheter care and not a SP catheter. LPN-B further acknowledged the order to monitor I/O each shift was not followed. LPN-B stated the expectation was I/O was monitored each shift, or nursing staff would chart why the task was not performed. LPN-B stated the care plan should indicate monitor I/O and for signs and symptoms of infection around the SP catheter insertion site, and should indicate the type of catheter the resident required. On 5/31/21 at 12:32 p.m., LPN-C stated a resident with a SP catheter would have orders to monitor I/O and for signs and symptoms of infection, orders to indicate the size of catheter required, and orders for dressing changes. LPN-C further stated an SP catheter should be mentioned on the care plan. On 5/31/23 at 1:19 p.m., the assistant director of nursing (ADON) stated the expectations for a resident with an indwelling catheter were orders that specified the type, size of catheter, catheter cares, and indications of dressings utilized around the tube at the insertion site with a dressing change frequency and for monitoring I/O. Additionally, the ADON stated I/O should be completed as ordered to ensure the resident received adequate fluid intake and had adequate urine output. If the task could not be completed as ordered, the reason why should be	F 690		

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F 690	Continued From page 6 documented. The ADON acknowledged R2's I/O were not completed as ordered without supporting documentation, The ADON further stated it was expected a resident with an indwelling catheter would have a care plan that indicated the type of catheter with interventions to care for the catheter, and acknowledged R2 did not have a care plan for a SP catheter, did not have orders for a SP catheter, and R2's medical record lacked documentation the catheter insertion site was cleaned. The ADON stated lack of proper care for the catheter could lead to infection. The ADON acknowledged the facility procedure lacked a frequency for cleaning a catheter insertion site and the standing orders that indicated a "similar-sized" catheter could replace an existing catheter could cause discomfort to a resident if a larger catheter replaced a smaller catheter, and only the catheter size ordered should replace an existing catheter. Facility Standing Orders revised April 2022 indicated care of an indwelling catheter as follows: - Do not irrigate - Change catheter PRN [as needed] for leaking or decreased urinary output using a similar-sized catheter - Change catheter and tubing prior to obtaining sample for UA/UC [urinalysis/ urine culture used to assess for urinary tract infection] - May attach leg bag when patient is out of bed; reattach to straight drainage when in bed The Facility Standing Orders lacked orders for cleaning the around the catheter insertion site, or the frequency for cleaning around the insertion site.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT CHATEAU LLC	2106 SECOND AVENUE SOUTH MINNEAPOLIS, MN 55404

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F 690	Continued From page 7 The facility Suprapubic Catheter Care procedure dated 10/10, indicated the purpose of the procedure was to prevent skin irritation around the stoma [opening in the body where the catheter was inserted] and to prevent infection of the resident's urinary tract. The procedure directed staff to review the resident's care plan for any special needs of the resident, and instructed how to perform the procedure, but lacked direction for how often the area should be cleaned. Additionally, the procedure indicated staff would document the procedure including the following: date and time the procedure was performed, the name and title of the individual(s) who performed the procedure, all assessment data obtained during the procedure, how the resident tolerated the procedure, if the resident refused the procedure, the reason(s) why and the intervention taken, results of skin assessment around the stoma site, character of the urine such as color, clarity, and odor, any problems or complaints made by the resident during the procedure, and the signature and title of the person recording the data. Further the procedure indicated notify the supervisor if the resident refused the procedure.	F 690		

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	00937	A. BUILDING: _____ B. WING _____	C 05/31/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/31/23, 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 reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52222412C (MN93918) with a licensing order issued at 4658.0525 Subp 5 A.B Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 residents (R1, R2, R3) reviewed for catheter use received appropriate physician orders for ongoing catheter care, a comprehensive care plan for indwelling catheters, and adequate catheter care documentation. R1's Diagnoses List printed 5/31/23, indicated	2 910	corrected	6/30/23

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2 910	Continued From page 3 T1's diagnoses included malignant neoplasm of bladder (bladder cancer) and hydronephrosis with renal and ureteral calculous obstruction (a blockage in the tube from the kidney to the bladder). R1's admission Minimum Data Sheet (MDS) dated 4/4/23, indicated R1 was cognitively intact, and had an indwelling catheter. R1's Care Area Assessment (CAA) DATE HERE indicated R1 had a nephrostomy tube (a tube placed through the skin of the lower back into the kidney for urine excretion) related to a diagnosis of right hydronephrosis (excess accumulation of urine in the kidney that causes swelling). The CAA further indicated to care plan to maintain current level of function. R1's hospital transfer information dated 3/28/23, indicated R1's right percutaneous nephrostomy tube was placed on 1/12/23. R1's Physician's Orders printed 5/31/23, lacked orders for the care of the nephrostomy tube. R1's care plan dated 3/29/23, lacked direction for nephrostomy tube care. R2's Diagnoses List printed 5/31/23, included urethritis (inflammation of the tube carrying urine from the bladder to the outside of the body), retention of urine, and anoxic brain damage (caused by complete lack of oxygen to the brain). R2's significant change MDS dated 4/12/23, indicated R1 was cognitively intact and had an indwelling catheter.	2 910		

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2 910	Continued From page 4 R2's Provider Order dated 2/16/23, indicated Foley catheter (a tube that passes through the urethra into the bladder to drain urine) for urinary retention, and an order dated 2/20/23, indicated monitor catheter output every shift. R2 lacked orders for a suprapubic (SP) catheter, and orders for the catheter size, insertion site cleaning, and dressing changes. R2's Urology provider note dated 3/10/23, indicated required an 18 French (FR) Foley catheter, and R1 should return to the clinic for catheter follow-up in 4-6 weeks. The medical record lacked indication R2 returned to the clinic in 4-6 weeks. R2's hospital discharge note dated 5/1/23, indicated R2 was seen at the Interventional Radiology Clinic for suprapubic catheter placement and to schedule a catheter exchange 4-6 weeks afterwards. R2's May 2023 Treatment Administration Record indicated from May 15 to May 30, 2023, the urinary output was not recorded as ordered 10 of 30 shifts. R3's Diagnoses List printed 5/31/23, included a spinal injury in the thoracic region, neuromuscular dysfunction of the bladder, and paraplegia. R3's quarterly MDS dated 3/2/23, indicated R3 was cognitively intact and had an indwelling catheter. R3's Physician's Orders printed 5/31/23, lacked orders for catheter size and catheter site care. R3's care plan dated 7/26/21, indicated monitor Foley catheter output, change Foley catheter per	2 910		

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2 910	Continued From page 5 policy, and provide catheter care per policy. R3's progress notes dated 5/13/23, and 5/28/23, indicated R3 was continent of bladder with no mention of a catheter. R3's medical record lacked documentation the catheter insertion site was cleaned. On 5/31/23 at 12:01 p.m., during observation, R1 had a split sponge dressing around the SP catheter at the insertion site next to his skin of his lower abdomen. During interview, R1 stated the dressing was changed, "About every other day but not every day." On 5/31/23 at 12:10 p.m., licensed practical nurse (LPN)-A stated the care plan for a resident with a SP catheter should include monitor fluid intake and urine output (I/O). LPN-A also stated the R2's care plan should have indicated the type of catheter R2 used, and should have indicated an SP catheter, not a Foley catheter. On 05/31/23 at 12:10 p.m., R3 stated catheter care is "not up to par." R3 explained he has to remind staff to clean the area around the catheter, and to empty the catheter drainage bag. R3 stated he notifies staff when his catheter needs changing, as he can feel when it starts to "back up." On 5/31/23 at 12:18 p.m., registered nurse (RN)-A stated there should be orders to change the catheter as needed, clean the catheter site, and record catheter output. The size of the catheter will be in the resident's physician orders or in the hospital paperwork. RN-A acknowledged R3's physician orders did not contain catheter size or catheter site care. RN-A stated she would	2 910		

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2 910	Continued From page 6 contact the physician to obtain catheter size if there was no order stating size. RN-A further stated physician orders should include what kind of catheter a resident has, and specific instructions on how to take care of it. On 5/31/23 at 12:19 p.m., LPN-B acknowledged R2 lacked orders for SP catheter care including dressing changes around the SP catheter insertion site. LPN-B acknowledged R2 had orders for a Foley catheter care and not a SP catheter. LPN-B further acknowledged the order to monitor I/O each shift was not followed. LPN-B stated the expectation was I/O was monitored each shift, or nursing staff would chart why the task was not performed. LPN-B stated the care plan should indicate monitor I/O and for signs and symptoms of infection around the SP catheter insertion site, and should indicate the type of catheter the resident required. On 5/31/21 at 12:32 p.m., LPN-C stated a resident with a SP catheter would have orders to monitor I/O and for signs and symptoms of infection, orders to indicate the size of catheter required, and orders for dressing changes. LPN-C further stated an SP catheter should be mentioned on the care plan. On 5/31/23 at 1:19 p.m., the assistant director of nursing (ADON) stated the expectations for a resident with an indwelling catheter were orders that specified the type, size of catheter, catheter cares, and indications of dressings utilized around the tube at the insertion site with a dressing change frequency and for monitoring I/O. Additionally, the ADON stated I/O should be completed as ordered to ensure the resident received adequate fluid intake and had adequate urine output. If the task could not be completed	2 910		

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2 910	Continued From page 7 as ordered, the reason why should be documented. The ADON acknowledged R2's I/O were not completed as ordered without supporting documentation, The ADON further stated it was expected a resident with an indwelling catheter would have a care plan that indicated the type of catheter with interventions to care for the catheter, and acknowledged R2 did not have a care plan for a SP catheter, did not have orders for a SP catheter, and R2's medical record lacked documentation the catheter insertion site was cleaned. The ADON stated lack of proper care for the catheter could lead to infection. The ADON acknowledged the facility procedure lacked a frequency for cleaning a catheter insertion site and the standing orders that indicated a "similar-sized" catheter could replace an existing catheter could cause discomfort to a resident if a larger catheter replaced a smaller catheter, and only the catheter size ordered should replace an existing catheter. Facility Standing Orders revised April 2022 indicated care of an indwelling catheter as follows: - Do not irrigate - Change catheter PRN [as needed] for leaking or decreased urinary output using a similar-sized catheter - Change catheter and tubing prior to obtaining sample for UA/UC [urinalysis/ urine culture used to assess for urinary tract infection] - May attach leg bag when patient is out of bed; reattach to straight drainage when in bed The Facility Standing Orders lacked orders for cleaning the around the catheter insertion site, or the frequency for cleaning around the insertion site.	2 910		

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2 910	Continued From page 8 The facility Suprapubic Catheter Care procedure dated 10/10, indicated the purpose of the procedure was to prevent skin irritation around the stoma [opening in the body where the catheter was inserted] and to prevent infection of the resident's urinary tract. The procedure directed staff to review the resident's care plan for any special needs of the resident, and instructed how to perform the procedure, but lacked direction for how often the area should be cleaned. Additionally, the procedure indicated staff would document the procedure including the following: date and time the procedure was performed, the name and title of the individual(s) who performed the procedure, all assessment data obtained during the procedure, how the resident tolerated the procedure, if the resident refused the procedure, the reason(s) why and the intervention taken, results of skin assessment around the stoma site, character of the urine such as color, clarity, and odor, any problems or complaints made by the resident during the procedure, and the signature and title of the person recording the data. Further the procedure indicated notify the supervisor if the resident refused the procedure. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents receive adequate catheter management. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD OF CORRECTION: Twenty-one (21) days.	2 910		

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