Electronically delivered

November 18, 2021

Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

RE: CCN: 245241
Cycle Start Date: September 15, 2021

Dear Administrator:

On October 6, 2021, we informed you that we may impose enforcement remedies.

On October 29, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 29, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 3, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 3, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 3, 2021.

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

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

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Northfield Hospital Long Term Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 29, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 15, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING ______ B. WING ______	C 10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	**2000 NORTH AVENUE NORTHFIELD, MN 55057**

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F 000	INITIAL COMMENTS	F 000		

On 10/28/21, through 10/29/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 10/23/21, when the tub chair with R1 in it, tipped back, and R1 struck his head on the tub resulting in a laceration that required six staples to close. The administrator, director of nursing (DON), and assistant director of nursing (ADON) were notified of the IJ at 6:18 p.m. on 10/28/21. The IJ was removed on 10/29/21, at 1:10 p.m.

The above findings constituted substandard quality of care, and an extended survey was conducted on 10/29/21.

At the time of the abbreviated survey, onsite investigations were completed and the following complaints were found to be substantiated :

H5241018C (MN77939) with deficiencies cited at F695.
H5241019C (MN77967, MN77980) with no deficiencies.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/24/2021

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 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the facility's tub chairs were in working order to prevent falls for 1 of 1 residents (R1), who fell while utlizing the tub chair. This resulted in an immediate jeopardy (IJ) for R1, who fell from the tub chair when the tub chair was not locked into place, tipped backwards, sustained head trauma and lacerations and required sutures. In addition, the facility failed to initiate a preventative maintenance (PM) program for the two Apollo Advantage Bathing System tubs according to manufacturer's recommendations. Findings include: The IJ began 10/23/21, when the tub chair with R1 in it, tipped back, and R1 struck his head on	F 689	On October 23, 2021, resident Elmer Lean, a patient of Dr. Steve Lawler *Genevive, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413) was being removed from the Apollo tub when the chair tipped backwards, and the resident head hit the tub. The resident received immediate emergency care (a neck collar was placed, and he was placed on a back board) then he was transported to the Emergency Room where he was evaluated. He required 6 staples to close his laceration. The laceration has healed, and the staples have been removed. On October 23, 2021, the facility took immediate action and removed the tub	11/24/21

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the tub resulting in a laceration that required six staples to close. The administrator, director of nursing (DON), and assistant director of nursing (ADON) were notified of the IJ at 6:18 p.m. on 10/28/21. The IJ was removed on 10/29/21, at 1:10 p.m.

R1's Diagnosis List printed on 10/28/21, indicated R1 had diagnoses of cerebral palsy and hearing loss.

R1's annual Minimum Data Set (MDS) dated 9/5/21, indicated he was cognitively intact.

A Nursing Home Incident Report (NHIR) submitted to the State Agency (SA) on 10/23/21, at 1:52 p.m. indicated at 7:10 a.m. on 10/23/21, R1 was being removed from a bathtub in a bathtub chair when the chair fell backwards and R1 hit his head on the tub. R1 was brought to the emergency room (ER) where he was treated, and returned to the nursing home.

On 10/23/21, a progress note indicated licensed practical nurse (LPN)-A was called to the east tub room at 6:45 a.m. by nursing assistant (NA)-A. When she entered the tub room, she noted R1 was in the tub chair which had tipped backwards. R1's head was resting against the entry of the tub. LPN-A noted that there was a moderate amount of blood present on the tub, floor, and towel which was placed on the back of R1's head. A fracture-collar was put around R1's neck to stabilize his neck. R1's bed was rolled down the hall to the east tub room with a backboard on the bed. R1 was lifted off the floor using a Hoyer (mechanical) lift and returned to his bed. LPN-A noted two open areas on the back of R1's head. R1 was transferred to the ER due to lacerations

F 689

from service until maintenance was able to fix the tub. On October 27, 2021, maint3enance found the tub pin was misaligned and fixed the issue.

On October 28, 2021, we were notified by the MDH surveyor that we had an Immediate Jeopardy related to noncompliance with the preventive maintenance to the Apollo Tub. We disagree that the situation warranted an immediate jeopardy. The immediate jeopardy status was a surprise to Facility Services also because we have a contracted service that is supposed to complete the preventative maintenance as required by the manufacturer. The contracted services did not notify us that it was not completing all the required preventive maintenance on the tubs.

The Immediate Actions that were taken that evening:
1. Immediately notified all staff working to not use either of the Apollo tubs.
2. Placed signage and tape on the Apollo tubs as a reminder.
3. Emailed with receipt all staff that the Apollo tubs should not be used until further notice.

On the morning of October 29, 2021, the manufacturer of the Apollo tub system was contacted to inspect the tubs to ensure they were safe to use and were fully functioning. The tubs were fully functional; the pin was locking since it was fixed on October 27, 2021, by our Facilities Services staff. The tubs were

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on the back of his head at 7:15 a.m. R1 returned to the facility on 10/23/21, at 8:30 a.m. with six staples which closed the lacerations on his head.

On 10/28/21, at 10:57 a.m. the east hallway tub room was observed with NA-A and the tub and tub chair were noted to be in working order. NA-A walked through how the incident involving R1 occurred using the tub and tub chair. NA-A stated on the morning of 10/23/21, she took R1 to the east hallway tub room. NA-A bathed R1 and then let the water out of the tub. R1 had a belt around his waist while he was in the tub chair. NA-A opened the tub door, rolled the footrest of the tub chair into position at the tub's entrance. NA-A stated the footrest would make a "clicking noise" to let staff know it was locked into place. NA-A stated she heard the tub chair click into place before attempting the transfer. NA-A stated she pulled the tub chair forward to the tub opening, and attempted to get the tub chair connected onto the footrest. NA-A stated when she pulled R1 forward in the tub chair, he and the chair fell backwards, and R1 hit his head on the tub. NA-A stated she called for help immediately, and LPN-A arrived on the scene shortly after. NA-A stated R1 was bleeding from his head and yelling in pain. NA-A stated she had not received any training on use of the Apollo tub or tub chair since the incident.

On 10/28/21, at 12:04 p.m. LPN-A was interviewed and stated NA-A had called her to come and help immediately after the fall. LPN-A stated she entered the bathroom and R1 was on his back with his head sitting on the edge of the bathtub. LPN-A stated there was a small to moderate amount of blood, she went to get more help, and multiple staff responded to assist.

cleared by the manufacturer. The manufacturer gave training to the Facilities Services on how to complete the preventive maintenance. The preventive maintenance occurred on that day. Because there was no ongoing risk to residents and the tub was safely operating well before the end of the day, we disagree with the finding of Immediate Jeopardy and intend to appeal.

On October 29, 2021, the Director of Facilities developed a preventive maintenance checklist to include all the required preventive maintenance items. The checklist will be kept in the Maintenance Office. The checklist will be reviewed by the Facilities Committee each meeting to ensure these are audited.

The following policies have been updated as 11/22/21:
1. Care of the Resident Sustaining a Fall:
a. If the fall was involving equipment or equipment malfunction immediately do the following after the resident has been taken care of:
   i. Pull the equipment from use and tag the equipment DO NOT USE.
   ii. Move the equipment out of the area - if able.
   iii. Notify Facilities Services by placing a maintenance request.
   iv. Ensure all staff are notified that equipment should not be used.
   v. Do not use the equipment until thorough inspection has been completed.
b. The LTCC Direct Caregivers will be educated on the process on November

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F 689	Continued From page 4 LPN-A stated R1 was sent to the ER at 7:15 a.m. LPN-A stated after the incident, she put in a work order for maintenance to assess and repair the east hallway tub. LPN-A stated the east hallway tub room was closed until it could be assessed by maintenance. LPN-A stated she did receive an e-mail instructing staff to make sure the footrest clicked into place before moving a resident out of the tub. On 10/28/21, at 12:32 maintenance manager (M)-A was interviewed, and stated he was not the person who worked on the Apollo tub in the east hallway tub room. M-A stated the facility used a contracted service, Agiliti, who provided preventative maintenance on the tubs. M-A stated on 10/23/21, a work order request was made for maintenance to inspect the east hallway tub. M-A stated on 10/27/21, he spoke to the DON who made him aware of the accident that occurred on 10/23/21, prompting M-A to assign M-B to inspect and repair the tub. M-A stated on 10/27/21, he initiated a new preventative maintenance plan (PM) for the tub chair safety docking pin only. M-A stated they did not reach out to the manufacturer for guidance. On 10/28/21, at 12:36 p.m. M-B was interviewed and stated he was assigned to work on the east hallway tub on 10/27/21. M-B stated the tub chair's safety docking pin for the footrest was misaligned and would not fully engage to keep the footrest of the chair locked into place. M-B stated he was able to make an adjustment to realign the pin with the hole that it should lock into. M-B stated they had not reached out to the manufacturer. On 10/28/21, at 1:39 p.m. the Agiliti medical	F 689	22, 2021. 2. Medical Equipment Management Plan: a. If any equipment isn't part of the Contracted Services MEMS, and requires preventive maintenance, the Contracted Service will notify Facilities Services to ensure proper preventive maintenance is performed on that piece of equipment. b. If only a portion of the manufacturer's recommended preventive maintenance is being performed by the Contracted Service, the Contracted Service will notify Facilities Services to ensure the remaining portion of proper preventive maintenance is performed on that piece of equipment. c. the Facilities Services Staff have been educated on the new process on November 22, 2021. All regular scheduled caregivers in the LTCC will complete the Apollo System competency by December 1, 2021, to ensure they are retrained to identify proper functionality of the tub. The casual staff and staff on leave will complete the competency on their first day back at work. The Plan of Correction completed November 24, 2021. The responsible person for the plan is Tammy Hayes the Administrator.	

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equipment manager (EM)-A was interviewed by telephone and stated he only provided preventative maintenance on the Apollo Advantage Bathing System's tub scale system that was used to weigh residents while in the tub chair. EM-A stated he did not provide preventative maintenance on any other part of the tub. EM-A stated it was the responsibility of the facility to perform all other PM.

On 10/28/21, at 3:00 p.m. M-A was interviewed again and stated both Apollo tubs were installed toward the end of 2016. M-A stated neither of the two tubs were inspected or had PM performed by facility personnel since the installation. M-A stated stated they still had not contacted the manufacturer for guidance.

On 10/28/21, at 3:09 p.m. the DON was interviewed and stated she was not working on 10/23/21. The DON stated she had sent out an e-mail to staff, re-educating them to make sure the footrest clicked into place before moving the tub chair forward to transfer a resident. The DON provided a copy of the email which read, "Hello everyone, hope you are all doing well. Several days ago, we had an incident with our Apollo tub chair base not locking in place that led to a resident falling and becoming injured. Today, maintenance confirmed the "pin" underneath the base had become misaligned and did not lock into the "receiver" that is located on the tub. It is vital that before you slide the resident onto the base be sure it locked in place. Give it a tug back, you also must be sure the brakes are locked. If it does not lock in can separate and cause injury to another resident. I have also requested that maintenance put the tubs on a routine check. This is kind of hard to describe in an e-mail and I

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F 689	Continued From page 6 would be happy to show you if you have any questions. Thank you!" The DON stated said she did not set up the e-mail that would require confirm, or receipt, to indicate the staff member had read the e-mail. The DON stated she did do some verbal training with some staff; however, she did not have training logs to support the training occurred. On 10/28/21, at 5:29 p.m. the administrator was interviewed. The administrator stated she was not aware the Apollo tubs were not on a maintenance schedule. The administrator stated Agiliti should be doing the PM, along with her facility maintenance staff. On 10/29/21, at 12:10 p.m. the Apollo Advantage Bathing System representative (R)-A was onsite at the facility and was interviewed. R-A stated he had just completed an inspection of both Apollo tubs that day. R-A stated the maintenance schedule recommendations from the manual should be followed to ensure the Apollo tubs were operating safely. R-A stated both tubs were now safe to resume use. R-A stated he would be providing education to the facility maintenance staff and assisting in developing a maintenance schedule. The manufacturer manual for the Apollo Advantage Bathing Systems recommended the safety docking pin be inspected on a monthly basis. A policy on preventative maintenance was requested, but not provided. The facility policy Care for Resident Sustaining a Fall revised 9/21, lacked direction for falls when	F 689		

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	245241	A. BUILDING ______ B. WING ______	C 10/29/2021

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F 689	Continued From page 7 they involved equipment or equipment malfunction. The policy also lacked direction on thorough inspection of equipment after a fall. The IJ was removed on 10/29/21, at 1:10 p.m. after the facility had the manufacturer come onsite to inspect both Apollo Advantage Bathing Systems to ensure they were operating safely, staff were educated on the equipment malfunction and safe tub use, manufacturer training was provided to the facility maintenance staff on repair and maintenance schedule, PM plan and log development, and an implemented plan for PM log audits. This was verified through observation, interview and document review.	F 689		

Electronically delivered
November 18, 2021

Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

Re: State Nursing Home Licensing Orders
Event ID: N1YI11

Dear Administrator:

The above facility was surveyed on October 28, 2021 through October 29, 2021 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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility’s Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NORTHFIELD HOSPITAL LONG TERM CARE C	**2000 NORTH AVENUE NORTHFIELD, MN 55057**

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2 000	Initial Comments	2 000		

*****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 10/28/21, through 10/29/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H5241018C (MN77939) with a licensing order issued at 4658.1665 Subp 3.E H5241019C (MN77967, MN77980) with no licensing orders 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 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	2 000		

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2 000	Continued From page 2 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		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the facility's tub chairs were in working order to prevent falls for 1 of 1 residents (R1), who fell while utlizing the tub chair. This resulted in an immediate jeopardy (IJ) for R1, who fell from the tub chair when the tub chair was not locked into place, tipped backwards, sustained head trauma and lacerations and required sutures. In addition, the facility failed to initiate a preventative maintenance (PM) program for the two Apollo Advantage Bathing System tubs according to manufacturer's recommendations. Findings include: The IJ began 10/23/21, when the tub chair with R1 in it, tipped back, and R1 struck his head on	21665	CORRECTED	11/24/21

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21665	Continued From page 3	21665		

the tub resulting in a laceration that required six staples to close. The administrator, director of nursing (DON), and assistant director of nursing (ADON) were notified of the IJ at 6:18 p.m. on 10/28/21. The IJ was removed on 10/29/21, at 1:10 p.m.

R1's Diagnosis List printed on 10/28/21, indicated R1 had diagnoses of cerebral palsy and hearing loss.

R1's annual Minimum Data Set (MDS) dated 9/5/21, indicated he was cognitively intact.

A Nursing Home Incident Report (NHIR) submitted to the State Agency (SA) on 10/23/21, at 1:52 p.m. indicated at 7:10 a.m. on 10/23/21, R1 was being removed from a bathtub in a bathtub chair when the chair fell backwards and R1 hit his head on the tub. R1 was brought to the emergency room (ER) where he was treated, and returned to the nursing home.

On 10/23/21, a progress note indicated licensed practical nurse (LPN)-A was called to the east tub room at 6:45 a.m. by nursing assistant (NA)-A. When she entered the tub room, she noted R1 was in the tub chair which had tipped backwards. R1's head was resting against the entry of the tub. LPN-A noted that there was a moderate amount of blood present on the tub, floor, and towel which was placed on the back of R1's head. A fracture-collar was put around R1's neck to stabilize his neck. R1's bed was rolled down the hall to the east tub room with a backboard on the bed. R1 was lifted off the floor using a Hoyer (mechanical) lift and returned to his bed. LPN-A noted two open areas on the back of R1's head. R1 was transferred to the ER due to lacerations on the back of his head at 7:15 a.m. R1 returned

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21665	Continued From page 4	21665		

to the facility on 10/23/21, at 8:30 a.m. with six staples which closed the lacerations on his head.

On 10/28/21, at 10:57 a.m. the east hallway tub room was observed with NA-A and the tub and tub chair were noted to be in working order. NA-A walked through how the incident involving R1 occurred using the tub and tub chair. NA-A stated on the morning of 10/23/21, she took R1 to the east hallway tub room. NA-A bathed R1 and then let the water out of the tub. R1 had a belt around his waist while he was in the tub chair. NA-A opened the tub door, rolled the footrest of the tub chair into position at the tub's entrance. NA-A stated the footrest would make a "clicking noise" to let staff know it was locked into place. NA-A stated she heard the tub chair click into place before attempting the transfer. NA-A stated she pulled the tub chair forward to the tub opening, and attempted to get the tub chair connected onto the footrest. NA-A stated when she pulled R1 forward in the tub chair, he and the chair fell backwards, and R1 hit his head on the tub. NA-A stated she called for help immediately, and LPN-A arrived on the scene shortly after. NA-A stated R1 was bleeding from his head and yelling in pain. NA-A stated she had not received any training on use of the Apollo tub or tub chair since the incident.

On 10/28/21, at 12:04 p.m. LPN-A was interviewed and stated NA-A had called her to come and help immediately after the fall. LPN-A stated she entered the bathroom and R1 was on his back with his head sitting on the edge of the bathtub. LPN-A stated there was a small to moderate amount of blood, she went to get more help, and multiple staff responded to assist. LPN-A stated R1 was sent to the ER at 7:15 a.m. LPN-A stated after the incident, she put in a work

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21665	Continued From page 5	21665		

order for maintenance to assess and repair the east hallway tub. LPN-A stated the east hallway tub room was closed until it could be assessed by maintenance. LPN-A stated she did receive an e-mail instructing staff to make sure the footrest clicked into place before moving a resident out of the tub.

On 10/28/21, at 12:32 maintenance manager (M)-A was interviewed, and stated he was not the person who worked on the Apollo tub in the east hallway tub room. M-A stated the facility used a contracted service, Agiliti, who provided preventative maintenance on the tubs. M-A stated on 10/23/21, a work order request was made for maintenance to inspect the east hallway tub. M-A stated on 10/27/21, he spoke to the DON who made him aware of the accident that occurred on 10/23/21, prompting M-A to assign M-B to inspect and repair the tub. M-A stated on 10/27/21, he initiated a new preventative maintenance plan (PM) for the tub chair safety docking pin only. M-A stated they did not reach out to the manufacturer for guidance.

On 10/28/21, at 12:36 p.m. M-B was interviewed and stated he was assigned to work on the east hallway tub on 10/27/21. M-B stated the tub chair's safety docking pin for the footrest was misaligned and would not fully engage to keep the footrest of the chair locked into place. M-B stated he was able to make an adjustment to realign the pin with the hole that it should lock into. M-B stated they had not reached out to the manufacturer.

On 10/28/21, at 1:39 p.m. the Agiliti medical equipment manager (EM)-A was interviewed by telephone and stated he only provided preventative maintenance on the Apollo

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21665	Continued From page 6	21665		

Advantage Bathing System's tub scale system that was used to weigh residents while in the tub chair. EM-A stated he did not provide preventative maintenance on any other part of the tub. EM-A stated it was the responsibility of the facility to perform all other PM.

On 10/28/21, at 3:00 p.m. M-A was interviewed again and stated both Apollo tubs were installed toward the end of 2016. M-A stated neither of the two tubs were inspected or had PM performed by facility personnel since the installation. M-A stated stated they still had not contacted the manufacturer for guidance.

On 10/28/21, at 3:09 p.m. the DON was interviewed and stated she was not working on 10/23/21. The DON stated she had sent out an e-mail to staff, re-educating them to make sure the footrest clicked into place before moving the tub chair forward to transfer a resident. The DON provided a copy of the email which read, "Hello everyone, hope you are all doing well. Several days ago, we had an incident with our Apollo tub chair base not locking in place that led to a resident falling and becoming injured. Today, maintenance confirmed the "pin" underneath the base had become misaligned and did not lock into the "receiver" that is located on the tub. It is vital that before you slide the resident onto the base be sure it locked in place. Give it a tug back, you also must be sure the brakes are locked. If it does not lock in can separate and cause injury to another resident. I have also requested that maintenance put the tubs on a routine check. This is kind of hard to describe in an e-mail and I would be happy to show you if you have any questions. Thank you!" The DON stated said she did not set up the e-mail that would require confirm, or receipt, to indicate the staff member

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21665	Continued From page 7	21665		

had read the e-mail. The DON stated she did do some verbal training with some staff; however, she did not have training logs to support the training occurred.

On 10/28/21, at 5:29 p.m. the administrator was interviewed. The administrator stated she was not aware the Apollo tubs were not on a maintenance schedule. The administrator stated Agiliti should be doing the PM, along with her facility maintenance staff.

On 10/29/21, at 12:10 p.m. the Apollo Advantage Bathing System representative (R)-A was onsite at the facility and was interviewed. R-A stated he had just completed an inspection of both Apollo tubs that day. R-A stated the maintenance schedule recommendations from the manual should be followed to ensure the Apollo tubs were operating safely. R-A stated both tubs were now safe to resume use. R-A stated he would be providing education to the facility maintenance staff and assisting in developing a maintenance schedule.

The manufacturer manual for the Apollo Advantage Bathing Systems recommended the safety docking pin be inspected on a monthly basis.

A policy on preventative maintenance was requested, but not provided.

The facility policy Care for Resident Sustaining a Fall revised 9/21, lacked direction for falls when they involved equipment or equipment malfunction. The policy also lacked direction on thorough inspection of equipment after a fall.

The IJ was removed on 10/29/21, at 1:10 p.m.

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21665	Continued From page 8 after the facility had the manufacturer come onsite to inspect both Apollo Advantage Bathing Systems to ensure they were operating safely, staff were educated on the equipment malfunction and safe tub use, manufacturer training was provided to the facility maintenance staff on repair and maintenance schedule, PM plan and log development, and an implemented plan for PM log audits. This was verified through observation, interview and document review. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures regarding tub and tub chair maintenance. The administrator or designee could educate all appropriate staff on the policies, procedures and equipment. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21665		