DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces the letter dated March 3, 2025 to show compliance.

Electronically delivered
March 11, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: December 6, 2024

Dear Administrator:

On January 6, 2025, we notified you a remedy was imposed. On March 4, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 6, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 6, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of , in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 6, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies such as Civil Money Penalty.

Feel free to contact me if you have questions.

Sincerely,

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

cc: File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 11, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

Re: Reinspection Results
Event ID: XIP112

Dear Administrator:

On January 29, 2025 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 December 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 19, 2024

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: December 6, 2024

Dear Administrator:

On December 6, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 March 6, 2025 (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 June 6, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

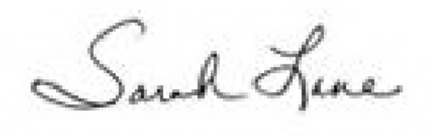
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 19, 2024

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: XIP111

Dear Administrator:

The above facility was surveyed on December 4, 2024 through December 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

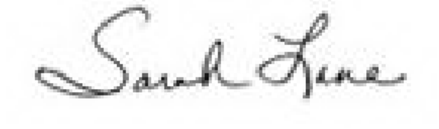
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 12/4/24 - 12/6/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H52792043C/MN108549 The following complaints were reviewed. H52792042C/MN108768 with deficiencies issued at F550, F558, F604, F656, F677, F684, F686, and F804 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		1/24/25

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

Electronically Signed | 12/27/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to treat with dignity for 1 of 3 residents (R7) reviewed for resident rights. A nursing assistant (NA)-C was observed speaking to R7 in a belittling manner while providing cares.	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	

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F 550	Continued From page 2 Findings include: R7's significant change Minimum Data Set (MDS) dated 7/25/24 indicated R7 had unclear speech, slurred or mumbled words. R7 could usually make himself understood. R7 did not have difficulty understanding others. R7's Brief Inventory of Mental Status (BIMs) of three indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and urine. R7's pertinent diagnoses were Huntington's disease (an inherited disease where the nerve cells in the brain break down), dysphagia (difficulty swallowing foods), and dorsalgia (back pain). Upon observation and interview on 12/6/24 at 11:40 a.m. nursing assistant (NA)-C went into R7's room to check on him. R7 was seated in his wheelchair reclined with his pommel restraint in place (a wheelchair cushion with a raised center section that keep the knees apart). NA-C walked in the room and said, "What the hell?" She noticed surveyor was observing and stated she was talking about the soap opera on his television on how in the hell the actors look like they did 30 years ago. NA-C asked R7 if he wanted to lay down. He shook his head and stated yes. She assisted him to his bed. His arms and legs were flailing when he was on his back in his bed. NA-C looked at surveyor and stated look how difficult he was to take care of with his movements. NA-C noticed R7's incontinence brief was wet along with the shorts he was wearing. NA-C placed clean shorts on him while he was on	F 550	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F550: Resident Rights/Exercise of Rights 1. Immediate re-education was provided to the staff member providing care to R7 prior to survey exit. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, all staff will be provided with education on treating residents with dignity and respect via the success center and an in-person meeting by 1/24/2025. The meeting will be conducted by the Director of Nursing Services or designee. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance Date ¿¿¿¿1/24/2025.	

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F 550	Continued From page 3	F 550		

the bed. She was unable to change his brief on his bed due to his movements. NA-C told R7 she would have to take him in the bathroom to change his brief, he nodded yes. She stood him up, sat him down in his wheelchair, wheeled him to the bathroom, stood him up by the toilet so he could hold onto handrails. NA-C pulled R7's shorts down and removed his brief at which point he passed gas. NA-C in a harsh tone said "seriously" and used his name. NA-C cleaned him with a wet wipe and placed a clean brief on him and sat him back in his chair. When asked her about her comments after he passed gas NA-C stated she was just joking around with him, and he knew that.

Upon interview on 12/6/24 at 11:46 a.m. R7 was asked using yes and no questions during the interview due to his aphasia (inability to communicate due to Huntington's disease) if NA-C was rough with him during the transfer process and he said "no." R7 was asked if he thought NA-C spoke kindly to him and he stated "No" and then said "I can't help how I am." R7 was asked if he felt that what NA-C said was verbal abuse and he stated "yes."

Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated she spoke with NA-C was told by NA-C that she was just joking around with R7. The DON provided immediate education to NA-C regarding treatment of residents and appropriate communication. The DON stated registered nurse, (RN)-C, spoke with R7 and R7 had no concerns about NA-C providing care to him.

Upon interview on 12/6/24 at 3:09 p.m. RN-C stated she spoke with R7, and he told her he was

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F 550	Continued From page 4 not uncomfortable with NA-C's comments, and he was comfortable working with her. A policy regarding dignity was not obtained.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights, or another means to request assistance were accessible for 4 of 4 residents (R5, R6, R7, and R8) reviewed who were dependent on staff for mobility. Findings include: R5's care plan revision date of 10/23/24 indicated to keep call light and television remote in place especially when R5 was in bed due to falls. R5's quarterly Minimum Data Set (MDS) dated 10/31/24 indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility.	F 558	F558: Reasonable Accommodations Needs/Preferences 1. R5, R6, R7, R8 were assessed for their ability to use their call light appropriately. Their care plans were updated with appropriate interventions as needed by 12/27/2024. 2. All residents who are dependent on staff for mobility have the potential to be affected by this deficient practice. A review of all residents who are dependent on staff for mobility will be completed to ensure appropriate interventions are in place by 12/30/2024. 3. To ensure systemic changes are sustained, all staff will be provided with education on the importance of keeping the resident□s call light accessible to them. This education will be provided by the Director of Nursing Services or designee via an in-person meeting by 1/24/2025. 4. To ensure compliance is maintained,	1/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

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F 558	Continued From page 5 Upon continuous observation on 12/6/24 at 9:14 a.m. R5 completed breakfast at 9:20 a.m. R5 was taken to her room by NA-C. R5 was in her Broda wheelchair (a medical device chair that provides comfort and support) with truck restraints (a padded cushion with a belt secured between the thighs of a patient in the Broda chair) on her lower extremities. R5 did not have a call light in place, the light was hanging on the wall. R5 was checked at 11:37 a.m. when NA-C checked on R5 and asked her if she wanted to lay down. R5 said "no." NA-C left the room without placing the call light within R5's reach. R6's MDS dated 10/24/24 indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. R6's pertinent diagnosis was Huntington's disease. R6's care plan dated 10/26/24 did not indicate the use of a call light or how R6 was to notify staff when assistance was needed. Upon continuous observation on 12/6/24 at 9:29 a.m. R6 was taken to her room by TMA-A. R6 was in her wheelchair in a reclined position with a pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart) in place. R6's call light was laying on top of her bed. At 10:34 a Hospice nursing assistant (NA)-D came to visit and provide cares. A hospice Registered nurse (RN)-F visited R6 at 11:30 a.m. and seated R6 at her lunch table in the commons area. Facility staff had not checked on R6 since leaving her in her room at 9:29 a.m. without her call light in place.	F 558	audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance Date 1/24/2025.	

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	245279	A. BUILDING _____ B. WING _____	C 12/06/2024

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F 558	Continued From page 6 R7's significant change (MDS) dated 7/25/24 indicated R7's Brief Inventory of Mental Status (BIMs) of 3 indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and bladder. R7's pertinent diagnose was Huntington's disease. R7's care plan dated 8/14/24 did not indicate the use of a call light or how R7 was to notify staff when assistance was needed. Upon continuous observation on 12/6/24 at 9:31 a.m. NA-C took R7 to his room. R7 was in a reclined wheelchair with a pommel cushion between his legs. R7 was placed next to his bed facing his television. R7's call light was hanging on his wall. R7 was not checked on again until 11:40 a.m. when NA-C went into his room and changed his incontinent brief. NA-C left his room at 11:44 leaving him in his chair without his call light within reach. R8's care plan dated 8/14/24 did not indicate the use of a call light or how R5 was to notify staff when he needed assistance, or another means to notify staff when assistance was needed. R8's quarterly MDS dated 10/10/24 indicated R8 had a BIMs score of 11 indicating moderate cognitive impairment. R8 was always incontinent of bowel and bladder. R8 required moderate assistance of staff for activities of daily living and transferring.	F 558		

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Upon continuous observation on 12/6/24 at 9:36 R8 was in his room with the door closed. R8 was in a wheelchair asleep approximately 10 feet from his bed. His call light was on the floor next to his bed.

At 9:36 a.m. TMA-A checked on R8 and was heard saying to a nursing assistant that R8 was still asleep he will get breakfast later. Call light was still on the floor and R8 had not moved in his wheelchair. At 10:31 a.m. TMA-A had again checked on R8, and he was still asleep in his wheelchair in the same position. The call was placed on the bed as the bed was made. R8 was still in his room at 11:50 when the surveyor left the unit.

Upon interview and observation on 12/6/24 at 11:35 a.m. NA-C stated that none of the residents can use the call light on the unit. She stated that is why they are checked on every two hours. She then stood up from the desk and went and checked on R5.

Upon interview on 12/6/24 at 2:15 p.m. trained medication assistant (TMA)-A stated R5, R6, R7 and R8 are all able to use their call lights, however they do not use them that is why staff forget to place the call lights within reach. He was not certain if call lights were on the care plans. TMA-A stated all the residents are checked on every two hours.

Upon interview on 12/6/24 at 2:26 p.m. RN-G stated R5 is not able to use a call light, her hands cannot function well enough to do so. R5 was supposed to be in the common area and not left alone in her room as she has tipped herself over in her wheelchair chair. R6 can use the call light

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F 558	Continued From page 8 as RN-G has seen her use it. R7 could use the call light if it were placed with him when he is seated in his chair in his room. R8 was able to use his call light. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing, DON stated call lights are a standard of practice and are not on the care plan and they should always be in reach for the resident's use. The DON was not certain if R5, R6, R7, or R8 were able to use the call light. She stated staff are to check on the residents frequently. She did not clarify how frequent, stating "depending on the resident." A facility policy titled Call Light with a revision date of 7/29/24 indicated the purpose was to ensure resident always had a method of calling for assistance. Staff was to place the call light within easy reach of the resident when leaving the room. For residents who are unable to use a call light, care plan appropriate interventions and provide adequate call light if applicable.	F 558		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F 604		1/24/25

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F 604	Continued From page 9 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to complete a proper assessment, care planning, and ongoing re-evaluation for the use of physical restraints for 5 of 5 residents (R4, R5, R6, R7, and R8) reviewed to ensure the imposed restraint were used to treat the resident's medical symptoms, is not used for convenience or discipline, is the least restrictive alternative for the least amount of time and document ongoing re-evaluation for the need of restraints. Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/28/24 indicated R4's Brief Inventory of Mental Status (BIMs) score of 1 indicated severe cognitive impairment. R4 required maximum assistance with personal hygiene, transferring	F 604	F604: Right to be Free from Physical Restraints 1. Nursing leadership will complete updated Physical Device and Restraint Assessments for R4, R5, R6, R7, and R8 and revise care plans as needed. Physician orders will be received as needed for anything deemed to be a restraint by 12/30/2024. 2. Any resident with a restraint has the potential to be affected by this deficient practice. All residents who have the potential to be affected will have their most recent Physical Device and Restraint Assessment reviewed and updated as needed, as well as having their care plans updated to reflect any changes. Physician orders will be received for restraints as needed.	

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F 604	Continued From page 10 and dressing. R4's pertinent diagnoses were Alzheimer's disease, adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, poor nutrition, inactivity and a decline in physical and mental functioning, pulmonary fibrosis (a lung disease which causes scarring making it difficult to breathe), and hallucinations. R4's physician order dated 10/25/24 indicated R4 used a Broda chair (a specialized wheelchair) with a back latching belt as needed for episodes of increased instability and confusion related to delusions/hallucinations. Staff was to document when using the restraint and document interventions attempted prior to use of the restraint (assist to rest in lounge chair, assist to sit with a snack, offer to lay down). Staff was to assess the need for thigh strap every 30 minutes and release every two hours to offload and reposition R4. R4's care plan dated 11/5/2020 - 12/6/24 indicated R4 used a back latching seat belt on a Broda chair, however the care plan did not identify the belt as a restraint and did not provide interventions for freedom of movement from the restraint following the orders to assessed need every 30 minutes and release every two hours. R4's care plan revision date of 7/14/21 indicated R4 was at risk for falls and had a history of falls related to mental distress, anxiousness and dementia, hallucinations, visuospatial deficient, anxiety, psychosis, altered balance, impaired judgement and incite of safety needs, has history of laying on the floor wandering dystonia, inability to sleep or rest, participate in daily routine, self-injurious behavior, physical ability decline and	F 604	3. To ensure systemic changes are sustained, all staff will be provided with education by the Director of Nursing Services or designee on the facility□s policy and procedure titled Restraints, via an in-person meeting by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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increased mental distress. R4's interventions were the use of a Broda chair with back latching seat belt as need for periods of increased stability, balance, confusion, delusion/hallucinated objections such as objects on the floor. When increased alertness, resident is able to walk without assistance or device. These interventions related to R4's falls, not the use of the restraint.

R4's care plan revision date of 12/12/22 indicated R4 had the potential for pressure ulcer development related to dementia, fluctuation in physical mobility, at times need for Broad chair and rear latching thigh straps, incontinence, and history of ulcer. R4's goal was to have intact skin free of redness, blisters, or discoloration. R4's interviews were to reposition/offload every two hours when in Broda chair. These interventions were related to pressure injuries not the use of the restraints.

R4's Physical Device and/or restraint evaluation and review dated 11/27/24 indicated R4 had a specialty wheelchair and a lap/seat belt. The review indicated education was provided with the family of the Broda chair and belt. The chair with back latching seat was used as needed for periods of increased instability, poor balance, confusion, delusion/hallucination that put resident at risk of falls and injury. When increased alertness and mobility resident is about to walk independently without device. Resident tolerates Broda chair well, does not seem agitated by it. Is able to independently mobilize himself in Broda. Allows resident to rest/mobile safely. Alternatives of decreased stimuli, individual behavior management, medication and clinical review and relaxation techniques were applied. The evaluation did not provide any documentation of

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interventions for resident to have freedom of movement from the restraints matching the providers orders.

R5's physician orders dated 2/3/21 indicated R5 had a Broda chair with a pommel cushion. No interventions for freedom of movement or the medical symptoms intended to treat were provided in the orders.

R5's care plan revision date of 8/2/24 indicated R5 was to be up in Broda chair with back latching bilateral thigh belt positioning device. R5 was to be offloaded and repositioning of the thigh belt every two hours. Staff to assist to propel Broda chair.

R5's quarterly Minimum Data Set (MDS) dated 10/31/24 indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility.

Upon observation on 12/6/24 at 9:04 a.m. R5 had a thigh belt restraint, not a pommel cushion as the physician orders indicated.

R6's signed physician orders dated 10/5/24 -11/5/24 did not indicate R6 used a Broda chair with a pommel cushion, interventions for freedom of movement or symptoms the restraint was intended to treat.

R6's Physical Device and/or restraint evaluation

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F 604	Continued From page 13 and review dated 10/19/24 indicated R6 had a soft helmet. R6's interventions were to release the soft helmet every two hours to offload and reposition. The evaluation did not mention the Broda chair with the pommel cushion. Upon observation on 12/6/24 at 9:04 a.m. R6 was seated in a reclined Broda chair with a pommel cushion between her legs. R7's signed physician order dated 10/5/24 - 11/5/24 did not indicate R7 used a Broad chair with a pommel cushion, interventions for freedom of movement or symptoms the restraint was intended to treat. Upon observation on 12/6/24 at 9:04 a.m. R7 was seated in a reclining Broda chair with a pommel cushion between his legs. R7's Physical Device and/or Restraint evaluation and review dated 9/30/24 indicated R7 had high-low bed, mattress on the floor and a specialty wheelchair (Broda). Informed consent was obtained, however the name of the person who gave informed consent was left blank. Alternative attempts were to decrease stimuli, physical therapy/occupation therapy, and redirecting. The evaluation did not indicate the devices were a restraint. R7's pommel cushion was not addressed on the evaluation. No interventions were completed and there was no documentation of family/resident education documented. R7's care plan revised date of 12/5/24 indicated Hospice and Occupational therapy were to assist with proper positioning, chair height. Broda chair with pommel cushion for safety. Assist to proper	F 604		

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F 604	Continued From page 14 height. Redirect to Broda as able. Trial of the new wheelchair date of 1/2023, consult with hospice. The care plan did not indicate any results or new interventions following the trial from 1/2023. The care plan did not identify any interventions for freedom or movement. R8's care plan revision date of 4/12/23 indicated R8 had a Broda chair with pressure redistribution cushion and self-releasing front latching seat belt. R8's care plan did not indicate interventions for freedom of movement or the symptoms the restraints were indented to treat. R8's signed physician orders dated 10/5/24 - 11/5/24 indicated R8 used a latching seat belt when he was up in his Broda chair. The orders did not indicate interventions for freedom of movement or the medical symptoms the restraint intended to treat. Upon interview on 12/5/24 at 11:48 a.m. the facility Medical Director stated the facility identified during the survey process that they did not have orders for some residents with restraints and he provided those residents with the orders required. The residents he provided orders for during the survey process were not identified. The Medical Director stated he was aware that assessments, education, consent, least restrictive method, and reassessments are required for restraint use and most of the residents with Huntington's disease used the restraints for repositioning. Upon interview on 12/5/24 at 1:12 p.m. registered nurse (RN)-C stated the residents should be assessed every 30 minutes to see if they still require the use of the restraint if the restraint is	F 604		

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F 604	Continued From page 15 being used for behaviors. RN-C stated she was aware there needed to be a reason for the restraint documented, the care plan must have interventions to when to apply or remove the restraint. She was not aware there needed to be a signed physician orders along with facility documentation of what symptoms the restraints were used to treat. Upon interview on 12/6/24 at 2:26 p.m. RN-G stated the staff were to check on the residents with restraints every two hours and staff is to document the restraint checks. RN-G stated R4, R5, R6, and R7 could not remove their restraints themselves. She was not certain if R8 could remove his lap belt himself. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing stated she is officially the infection preventionist and is filling for the DON for a leave, so she was not certain exactly how the facility monitors to make sure the care plans, orders and assessments have all of the required criteria for restraints. A facility policy titled physical restraints/psychotropic medications alternatives dated 4/2/24 identified alternatives to use for physical restraints or psychotropic medications including environmental, physical, equipment and psychosocial. The policy indicated the risks to residents when a physical restraint is used: falls, accidental death, functional decline, skin breakdown, depression, decreased self-esteem, loss of control, anger, increased agitation, reduced appetite, decreased quality of life, power issues, family stress, loss of dignity, reduced bone mass, loss of muscle tone, strangling, suffocation, bruising, cuts scrapes, feeling of	F 604		

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F 604	Continued From page 16 isolation and entrapment. The facility provided a bed assessment and side rail safety, focused audit with a revision date of 9/17/24. The policy was not specific to the use of restraints.	F 604		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		1/24/25

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F 656	Continued From page 17 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement the person-centered care plan for 2 of 4 residents (R5 and R7) reviewed to meet the resident's needs. In addition, the facility failed to complete a person-centered care plan for 2 of 4 residents (R4 and R6) to describe the residents medical needs. Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/28/24 indicated R4's Brief Inventory of Mental Status (BIMs) score of 1 indicated severe cognitive impairment. R4 required maximum assistance with personal hygiene, transferring and dressing. R4's pertinent diagnoses were Alzheimer's disease, adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, poor nutrition, inactivity and a decline in physical and mental functioning, pulmonary fibrosis (a lung disease which causes	F 656	F656: Develop/Implement Comprehensive Care Plan 1. Nursing leadership will review the care plans of R4 and R6 to ensure they remain accurate and appropriate. This review will be completed by 12/30/2024. 2. All residents who use restraints have the potential to be affected by this deficient practice. Nursing leadership will review the care plans of all residents with restraints to ensure they remain accurate and appropriate. This review will be completed by 12/30/2024. 3. To ensure systemic changes are sustained, all nursing staff will be provided education by the Director of Nursing Services or designee on Restraints and the importance of following care planned interventions for all residents. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and	

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	245279	A. BUILDING _____ B. WING _____	C 12/06/2024

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F 656	Continued From page 18 scarring making it difficult to breathe), and hallucinations. R4's physician order dated 10/25/24 indicated R4 used a Broda chair (a medical device chair that provides comfort and support) with back latching belt as needed for episodes of increased instability and confusion related to delusions/hallucinations. Staff was to document when using the restraint and document interventions document interventions attempted prior to use of the restraint (assist to rest in lounge chair, assist to sit with a snack, offer to lay down). Assess need for thigh strap every 30 minutes and release every two hours to offload and reposition R4. R4's care plan dated 11/5/2020 - 12/6/24 did not indicate R4 was to be assessed every 30 minutes for the thigh strap and release every two hours to offload and reposition. R5's care plan intervention revision date of 12/12/23 indicated R5 was unsafe to use the toilet, staff was to check and change her incontinent brief every two hours and assist with bowel movements as needed. R5's care plan intervention revision date of 8/2/24 indicated R5 was to be up in Broda chair with back latching bilateral thigh belt positioning device. Offload and reposition thigh belt every two hours. Staff was to assist R5 to propel Broda chair. R5's care plan intervention dated 7/24/24 indicated R5 was to be turned/repositioned every two hours due to potential for pressure ulcers related to incontinence.	F 656	monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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F 656	Continued From page 19 R5's care plan dated 9/19/24 indicated R5 was to be kept in the common area as resident allows when up in her Broda chair due to falls. R5's quarterly Minimum Data Set (MDS) dated 10/31/24 indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility. Upon continuous observation on 12/6/24 at 8:41 a.m. R5 was seated in her Broda chair with the trunk restrain buckled over her thighs. R5 completed breakfast at 9:20 a.m. R5 was taken to her room by NA-C. R5 was in her Broda wheelchair with truck restraints (a padded cushion with a belt secured between the thighs of a patient in the Broda chair) on her lower extremities. R5 was not checked until 11:37 a.m. when NA-C checked on R5 and asked her if she want to lay down, R5 was still in her Broda chair with her trunk restraints on. R5 was not repositioned, her incontinent brief was not checked or changed, and was not asked if she wanted to be in her room or in the common areas indicated for safety as her care plan indicated. R6's Physical Device and/or restraint evaluation and review dated 10/19/24 indicated R6 had a soft helmet. R6's interventions were to release the soft helmet every two hours to offload and reposition. The evaluation did not indicate any interventions for the Broda chair reclined with the	F 656		

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F 656	Continued From page 20	F 656		

pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart), which R6 was using.

R6's MDS dated 10/24/24 indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder.

Upon continuous observation R6 was taken to her room by TMA-A at 9:29 a.m. R6 was in her wheelchair in a reclined position with a pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart) in place. R6's call light was laying on top of her bed. At 10:34 a Hospice nursing assistant (NA)-D came to visit and provide cares for R6. A hospice Registered nurse (RN)-F visited R6 at 11:30 a.m. and seated R6 at her lunch table in the commons area. Facility staff had not checked on R6 since leaving her in her room at 9:29 a.m. R6 was not checked on as her care by facility staff every two hours as indicated.

R7's significant change (MDS) dated 7/25/24 indicated R7's Brief Inventory of Mental Status (BIMs) of 3 indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and bladder. R7's pertinent diagnose was Huntington's disease.

R7's care plan with a revision date of 6/13/24 indicated R7 was to remind/assist to turn and reposition every two hours. Encourage R7 to lay

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F 656	Continued From page 21 down after means due to history of stage two pressure ulcers on buttocks. R7's care plan with a revision date of 9/20/24 indicated R7's incontinent brief was to be checked and changed every two hours and as needed. Staff was to apply barrier cream at least once per shift due to pressure ulcers. Upon continuous observation on 12/6/24 at 8:41 a.m. R7 was seated in his Broda chair with his pommel cushion between his legs. At 9:31 a.m. NA-C took R7 to his room. R7 was still seated in his reclined wheelchair with a pommel cushion between his legs. R7 was placed next to his bed facing his television. R7 was not checked on again until 11:40 a.m. when NA-C went into his room and changed his incontinent brief by laying him on his bed for a few minutes and then standing him by the toilet to change the pad. He was then sat back in the Broda with the pommel at 11:46 a.m. R7 was not offered a position change or asked if he wanted to lay down until 11:40 a.m. R8's care plan dated 7/28/11 - 12/5/24 did not indicate R8 had a Broda chair with a front latching seat belt or any parameters or interventions for the use. R8's quarterly MDS dated 10/10/24 indicated R8 had a BIMs score of 11 indicating moderate cognitive impairment. R8 was always incontinent of bowel and bladder. R8 required moderate assistance of staff for activities of daily living and transferring. Upon observation on 12/5/24 at 2:50 p.m. R8 was observed in a Broda chair with a front latching	F 656		

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F 656	Continued From page 22 seat belt. Upon interview on 12/6/24 at 11:36 a.m. nursing assistant (NA)-C stated she did not ask R7 if he wanted to lay down after breakfast because he never stays in bed and his care plan should not say that. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing (DON) stated her expectation is that the care is followed and is person-centered to and up to date. A facility policy titled Care Plans with a revision date of 12/2/24 indicated the comprehensive care plan includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide 1 of 3 residents (R3) reviewed who was unable to carry out activities of daily living (ADL's) the necessary services to maintain proper personal hygiene. Findings include: A facility grievance log dated 8/23/24 indicated R3 had complaints regarding cares indicating a resolution date of 9/12/24. No further	F 677	F677: ADL Care Provided for Dependent Residents 1. Nursing leadership will review R3□s care plan to ensure appropriate interventions are in place for ADL care. This review will be completed by 12/30/2024. 2. All residents who are dependent on staff for ADL care have the potential to be affected by this deficient practice. Nursing leadership will review the care	1/24/25

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F 677	Continued From page 23 documentation was provided upon request. A facility grievance log dated 10/8/24 indicated R3 had complaints regarding cares with a resolution date of 10/28/24. No further documentation was provided upon request. R3's physician orders dated 10/22/24 indicated to keep peri area clean and dry every shift. R3's hospital discharge summary dated 11/10/24 indicated R3 was septic due to catheter related urinary tract infection. R3 was discharged back to the facility on 11/15/24. R3's care plan revision dated 11/15/24 indicated R3 had an ADL self-care performance deficit related to central cord syndrome at C5 (spinal cord injury which the spinal cords ability to transmit messages from the brain), post-traumatic stress disorder, gastric bypass for obesity, fibromyalgia (body pain and tiredness), sepsis due to catheter related urinary tract infections, cough with atelectasis (collapse of part of the lung), and fatigue needs assistance with ADLs. R3's goals were to improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. Interventions were: Personal hygiene resident required one staff maximum assist. Two staff as able for perineal care. Toilet use resident required two staff maximum assistance check and change every two hours. Catheter care by nursing assistant twice daily. R3's re-admission MDS dated 11/21/24 indicated R3's BIMs score was a 15 indicating R3 was cognitively intact. R3's was assessed and did not	F 677	plans of the residents who are dependent on staff for ADL care to ensure that appropriate interventions are in place. This review will be completed by 12/30/2024. 3. To ensure systemic changes are sustained, education on the facilities policy and procedure Perineal Care will be provided to all nursing staff. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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F 677	Continued From page 24	F 677		

have any behaviors or rejection of cares. R3 was totally dependent on staff for toileting hygiene and lower body dressing. R3 required extensive assistance with transferring, rolling left and right, and upper body dressing. R3 had an indwelling urinary catheter. R3 was frequently incontinent of bowel. R3's pertinent diagnoses were encounter for orthopedic aftercare, central cord syndrome at C5, spinal stenosis cervical region (spaces in the backbone become too small causing pressure), spondylosis cervical region (wear and tear of the spine), weakness, and morbid obesity.

Upon interview on 12/5/24 at 9:01 a.m. registered nurse (RN)-E stated R3 had made multiple complaints to the facility. She stated she recalled one complaint about call lights and R3 was given a highly sensitive button to push. She stated she could not recall the other complaints but would provide the documentation to the surveyor.

Upon observation and interview on 12/5/24 at 12:20 p.m. R3 stated the concern she had was staff was not cleaning her peri-area appropriately or not at all and she has been in the hospital recently for a urinary tract infection. She stated she had made complaints to the facility and was told staff had been educated about the need to properly clean her. R3 stated she was educated in the hospital about the importance of making sure her peri-area is kept clean and dry. R3 stated earlier on 12/5/24 nursing assistant (NA)-B came into the room, got a washcloth wet and handed it to R3 to wash her face. R3 stated peri-care was not completed and her catheter bag had not been emptied. R3 pressed her call light and trained medication assistant (TMA)-B answered the light and emptied her catheter bag upon her request R3 had 1700 cubic centimeters

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F 677	Continued From page 25 (cc) of urine in the bag. TMA-B apologized for the bag not being emptied sooner. R3 told TMA-B that the surveyor would like to visualize her wounds, so a time was set-up for 1:30 p.m. on 12/5/24. Upon observation and interview on 12/5/24 at 1:45 p.m. RN-D, NA-B and an unidentified NA turned R3 onto her left side. R3's incontinent pad was dry and no odors present. R3 asked NA-C to please clean her up since she had only handed her a wash clothing for her face in the morning. NA-C stated she was going to go back complete peri-care for R3 but had not had time. The staff positioned R3 on her back. NA-C filed a basis with soap and water. NA-C cleansed between R3's labial folds and along the catheter tubing with the first wash cloth, there was dried blood and dried feces on the washcloth. NA-C used a second washcloth and wiped away again dried feces. The staff again placed R3 on her left side and NA-C used a third washcloth and wiped away a small amount of soft feces. A fourth washcloth was used and wiped away a small amount of soft feces in the buttock crease. NA-C then took a wet wipe and cleaned the rest of R3's buttocks. RN-D stated to NA-C R3 should have been cleaned-up in the morning to be kept clean and dry. Upon interview on 12/5/24 at 2:12 p.m. NA-C stated she was going back to clean-up R3 but had not had time. In addition, she stated R7 refuses cares often. She denied reporting to nursing staff or trying to get assistance from other staff. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing stated R3 had been	F 677		

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F 677	Continued From page 26 hospitalized multiple times with urinary tract infections. She stated R3 refuses cares often, but staff were able to properly clean her. A facility policy on activities of daily living for dependent residents was requested and not received.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide professional standards of practice for 2 or 3 residents (R6 and R9) reviewed when residents were observed wearing two incontinence briefs placed on them at the same time. Findings include: R6's quarterly Minimum Data Set (MDS) dated 10/24/24 indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. R6's pertinent diagnosis was Huntington's disease.	F 684	F684: Quality of Care 1. Nursing leadership will initiate a 72-hour bowel and bladder assessment for R6 and R9 to evaluate their toileting patterns. Their care plans will be updated following this assessment. This will be completed by 12/30/2024. 2. All residents who are dependent on staff for toileting have the potential to be affected by this deficient practice. Nursing leadership will review the toileting records of these residents and initiate 72-hour bowel assessments as needed based on the review of the records. This review will be completed by 12/30/2024. 3. To ensure systemic change is sustained, all nursing staff will be provided	1/24/25

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F 684	Continued From page 27 R6's care plan dated 10/26/24 indicated for staff to check and change R6's incontinent brief every two hours. The care plan did not indicate R6 was to wear two incontinent briefs at the same time. Upon observation and interview on 12/6/24 at 11:05 a.m. hospice nursing assistant (NA)-D completed a bed bath on R6 and stated she had soaked through both briefs the facility had put on her. NA-D showed surveyor two saturated incontinent briefs in a plastic bag as he was exiting her room. He stated he finds "often" that residents on the unit are "double briefed." Upon interview on 12/6/24 at 11:26 a.m. hospice registered nurse (RN)-J stated staff "double brief" R6 as she urinates often. She was uncertain how often facility staff checks and changes R6's incontinent brief or if they attempt to sit her on the toilet. Upon interview on 12/6/24 11:34 a.m. R6 stated "yes" staff puts two incontinent briefs on her. She stated "no" that hospice NA-D did not put two briefs on her. R9's quarterly MDS dated 10/24/24 indicated R9's BIMs score was three indicating severe cognitive impairment. R9 was dependent for toileting hygiene, bathing, and dressing. R9 was always incontinent of bowel and bladder. R9's pertinent diagnosis was Huntington's disease. R9's care plan dated 9/20/22 indicated R9's incontinent brief was to be checked and change every two hours. The care plan did not indicate R9 was to wear two incontinent briefs at the same time.	F 684	with education on the facilities policy and procedure related to bowel and bladder function. This education will be provided by the Director of Nursing Services or designee. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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F 684	Continued From page 28 Upon observation on 12/6/24 at 11:16 a.m. NA-D requested the surveyor to R9's room to show that R9 was seated in her wheelchair wearing two incontinent briefs. Upon interview on 12/6/24 at 11:36 a.m. NA- C stated it is not okay to "double brief" residents and she has never done so. Upon interview on 12/6/24 at 2:15 p.m. trained medication assistant (TMA)-A stated it was not okay to "double brief" a resident and he had seen it a few times on the unit, but he was not aware who of h staff was doing it. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated it was not appropriate to "double brief" residents, staff should be checking and changing their incontinent brief at least every two hours. If a resident needed additional protection, they would expect staff to place a pad inside the incontinent brief if the care plan would instructions indicated. The DON was not aware that "double briefing" was taking place on the unit. A policy regarding quality of care was requested and not received.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		1/24/25

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	245279	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess and initiate interventions to minimize the risk for pressure ulcer development for 1 of 3 residents (R1) reviewed. Findings include: According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, indicated: -"Pressure Ulcer/Injury (PU/PI)" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. - "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors;	F 686	F686: Treatment/Services to Prevent/Heal Pressure Ulcers 1. R1□s care plan included interventions related to prevention and treatment of pressure ulcers. R1 no longer resides at the facility. 2. All residents with a Braden Score of 18 or less have the potential to be affected by this deficient practice. Nursing leadership or designee will complete updated skin checks to ensure there are no unidentified skin concerns on or before 12/30/2024. Care plans will be updated as appropriate. 3. To ensure systemic changes are sustained, all nursing staff will be provided education by the Director of Nursing Services or designee on the facility□s policy and procedure Skin assessment Pressure Ulcer and Documentation. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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F 686	Continued From page 30 define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. -Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). -Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). R1's care plan dated 10/19/24 indicated R1 had a potential for pressure ulcer development due to dementia, incontinence, refusal of cares and for assistance with mobility. R1's goal was to have intact skin, free or redness, blisters, or discoloration. R1's interventions were to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc. noted during baths or daily care	F 686		

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F 686	Continued From page 31 and to explain and reinforce to resident the importance of adequate intake. The care plan identified on 10/21/24 R1 had inadequate protein-energy intake related to poor appetite as evidenced by consuming less than 50% of meals and weight loss greater than 5% in less than 30 days. R1's care plan failed to incorporate interventions to prevent the development of pressure ulcers. R1's dietary assessment dated 10/21/24 indicated R1 had significant weight loss of 5% in 30 days. R1 was at risk for malnutrition, weight loss, reduced muscle mass. R1 had inadequate protein intake and a Braden skin assessment score of 15 upon admission. R1's quarterly Minimum Data Set (MDS) dated 11/6/24 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 5 indicating he was severely cognitively impaired. R1 did not have behaviors or refusal of cares. R1 required extensive assistance with bed mobility, transfers, eating, and toilet use. R1's pertinent diagnosis was Parkinson's disease. R1 had no pressure ulcers. R1 was not receiving any skin and ulcer/treatments. R1's skin assessment dated 11/26/24 indicated R1 had dry skin, but no bruising, abrasions, skin tears, rash, or pressure injuries. R1's Braden Scale for Predicting Pressure risk (admission/readmission) dated 11/27/24 indicated R1 had a score of 16 and was at mild risk for pressure ulcer. A score of 15-18 indicated R1 was a mild risk. Mild risk interventions guideline included: -Frequent turning every two hours.	F 686		

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F 686	Continued From page 32 -Maximal remobilization -Protect heels. -Manage moisture, nutrition, friction, and shearing. -If other major risk factors present (advanced age, poor dietary intake of protein, diastolic blood pressure below 60, hemodynamic instability) (the body cannot maintain consistent blood flow and pressure), advance to the next level of risk. R1's skin assessment dated 11/28/24, indicated R1 had a right hip moisture associated skin damage (MASD) stage 1 pressure ulcer (intact skin with a localized area of non-blanchable redness) 9x13 centimeters (cm), barrier cream and foam dressing applied. R1's family, primary care provider and the nurse manager were notified. R1's care plan revision date of 11/29/24 indicated the resident had potential for impairment to skin integrity related to thin and fragile skin of the right hip. R1's goal was to be free from skin injury through the review date of 1/18/25. R1's interventions were to monitor the location, size, and treatment of the skin injury. Report abnormalities, failure to heal, s/s of infection, maceration etc. to the health care provider. Identify potential causative factors and eliminate/resolve where possible. Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. The care plan did not identify that R1 had acquired an actual pressure ulcer nor the treatment for the pressure ulcer. The care plan did not include any additional interventions. R1's nursing progress note dated 11/29/24 at 1:05 p.m. indicated the R1's nurse practitioner	F 686		

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F 686	Continued From page 33 (NP) was left a message updating her on R1's right hip ulcer requesting treatment. R1's nursing progress note dated 11/29/24 at 9:42 p.m. indicated NP would see R1 Monday (12/2/24) before referring R1 to the wound provider. No orders were provided. R1's electronic treatment administration record (eTAR) dated 11/29/24 indicated a nursing order was placed to cleanse area on right hip daily, pat dry and apply foam dressing to area. The order was placed on hold from 11/29/24 to 12/1/24. No other treatment orders for the wound were on the eTAR. R1's hospital admission note dated 11/29/24 at 10:30 p.m. indicated: -R1 had a pressure injury to his right toe. -R1 had a pressure injury or blanchable erythema middle sacrum, -R1 had a pressure injury Stage 2 to the right hip (a partial thickness loss of the skin, appearing as a shallow open sore or blister, where the top layer of skin and potentially the deeper layer are damaged resulting in a visible wound. -No other information was documented. R1's hospital Braden score dated 11/29/24 indicated R1 had a Braden score of 12 indicating R1 was at a moderate risk for developing pressure ulcers. R1's care progression note dated 12/2/24 indicated R1 was on comfort cares. R1 moaned and groaned with turns as right hip was tender from pressure injury, dressing was changed as needed.	F 686		

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F 686	Continued From page 34	F 686		

R1's palliative care encounter note dated 12/2/24 indicated family explained to the provider R1 was neglected at the facility which resulted in the pressure sores and poor nutrition. He began to decline at the facility eventually not eating independently, lying in bed most of the time and less responsive to staff and family.

Upon interview on 12/4/24 at 12:18 p.m. nursing assistant (NA)-A stated on 11/28/24 she found redness on R1's right hip and reported it to the nurse immediately. She stated it was a large triangle area over the bone with tinged blood. She stated it looked like he had "laid on it a long time." She did notice redness on R1's coccyx, stating it did not have blood like his hip and that it did not need to be reported to the nurse because the NAs could use cream on the coccyx.
NA-stated she did not notice any skin concerns with R1's feet. NA-A stated she was never told to reposition R1 when he was in bed or use any heel protectors.

Upon interview on 12/4/24 at 12:40 p.m. registered nurse, (RN)-A stated he was the nurse who sent R1 to the hospital on 11/29/24. He was not aware of any skin concerns with R1. He stated there were not treatments ordered, no staff mentioned any skin concerns to him, and it was not R1's day for a skin assessment.

Upon interview on 12/4/24 at 2:52 p.m. RN-B stated she was a float nurse and was the nurse who NA-A reported R1 had a pressure ulcer on his right hip. She stated his hip appeared to have a large upside-down triangle on it over his bony prominence. The skin was intact. R1 tended to lay on his right side often. RN-B stated she put barrier cream on the pressure ulcer and covered

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F 686	Continued From page 35	F 686		

it with a dressing. She notified the family, the nurse manager, and the nurse practitioner. She did not follow-up to see R1 had received any skin care orders.

Email correspondence on 12/5/24 at 7:42 a.m. from R1's family member (FM)-A revealed seven photos taken on 11/29/24 at approximately 7:00 p.m. in the hospital emergency room.

Image 1 revealed a red, raised area on the anterior midsection of R1's right foot.
Image 2 revealed bilateral redness and peeling of the skin on R1's buttock from the top of the intergluteal crease to below the sacrum into the gluteal folds. The redness covers one-half of the gluteus maximus bilaterally. Skin appeared dry. Inside the gluteal fold could not be observed.
Image 3 and 4 revealed rightness over R1's entire right heel and redness on the bony prominence posterior to the right big toe. R1's foot appeared excessively dry.
Image 5 and 7 revealed a blister, full eschar (scab) over the medial bony prominence of R1's right big toe.
Image 6 revealed a raised, red area with three-quarters of the area open and appeared to have serosanguinous (blood and serum fluid from the wound) drainage, well defined edges. Peeling of the epidermis noted on the anterior and posterior part of the wound. Surrounding skin appeared dry.

Upon interview on 12/5/24 at 12:12 p.m. the facilities Medical Director stated on the admission the facility completes a full skin assessment and then on a weekly basis the day resident's shower. He stated "it depends" if weekly skin assessments are enough stating it would be the

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F 686	Continued From page 36	F 686		

nurse's judgement such as mobility, nutrition, diagnosis, etc. He stated skin breakdown can occur quickly for instance if a resident is septic (blood infection) or someone with vascular problems skin conditions can change within hours especially in the lower extremities (legs and feet). He stated in very debilitated residents the skin can change from one week to another. Regarding R1's coccyx pressure ulcer the NAs should have noticed that when they were changing R1's incontinent briefs.

Upon interview on 12/5/24 at 1:12 p.m. RN-C the nurse manager stated she was aware of R1's wound. She stated the wound happened on a holiday 11/28/24 and was aware the NP would see R1 on the following Monday 12/2/24 however, R1 was transferred to the hospital on 11/29/24. RN-C stated she would have guessed R1 would have had a low Braden score and was surprised it was a 16. She stated he was admitted following significant weight loss, was incontinent of bowel and bladder, had dementia and was chair bound. She stated with a lower Braden score R1 would have had more interventions. RN-C did not elaborate on what more interventions could have been place. RN-C was shown pictures taken with permission of R1's family in the emergency room and stated the staff should not have missed those pressure ulcers.

Upon interview on 12/6/24 at 4:30 p.m. R1's NP stated she recalled being called about "redness" on R1's hip measuring 9 x 13 cm. She stated she told the facility she would look at on 12/2/24 on her rounds. She stated she would have expected the facility to keep it covered, use barrier cream, assess, and turn and reposition him until then. She stated she was not informed of any other

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F 686	Continued From page 37 skin concerns for R1. She stated she read R1's hospital notes and the documented pressure ulcers and stated the facility should have caught those as those type of wounds would not have happened within hours during the transfer from the facility to the hospital. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated the facility has skin assessments in place on admission and weekly thereafter. She stated the NAs are trained to notify the nurse with any skin changes and did notify the nurse with R1's hip pressure ulcer. She stated the facility staged the ulcer at a one and they should have been providing care there. She stated R1's other skin altercations should be noticed at the facility. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation Requirements with a revision date of 4/26/24 indicated all residents will be identified for their risk of developing pressure ulcers on admission/readmission by a registered nurse using the Braden Scale predicting pressure risk UDA. Those residents determined to be at risk will have the Braden scale completed weekly for the first four weeks. A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant is responsible for this and will report any abnormal findings or signs of skin impairment to the licensed nurse.	F 686		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		1/24/25

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F 804	Continued From page 38 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the proper temperature of food was served at breakfast on the 2nd floor WL unit. This had the potential to affect all 16 residents. Findings include: During observation on 12/6/24 at 8:41 a.m. staff was in the kitchenette area where scrambled eggs in steam tables. At 9:00 a.m. two nursing assistants and one trained medication assistant were dishing and serving breakfast. At 9:06 a.m. R6 was given pureed eggs to feed herself. She was heard shouting her eggs were cold, R6 was not offered to have her food heated up. At 9:10 a.m. surveyor tasted a spoonful of eggs that were sitting outside on a plate of the steam tables and the eggs were cold. Upon interview on 12/6/24 at 9:11 R9 nodded "yes" that her breakfast was cold. Upon observation and interview on 12/6/24 at 9:46 a.m. R7 stated his breakfast cold and "always is." R7's food was sat on the table at 9:14 and he was fed at 9:21. R7's food was not covered on the table. Upon interview on 12/6/24 at 2:15 a.m. trained	F 804	F804: Nutritive Value/Appearance, Palatable/Prefer Temp 1. All residents have the potential to be affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, education will be provided to all nursing and dietary staff by the Director of Nursing Services or designee on the facility□s policy and procedure related to Food Temperature and Monitoring and Food Service. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for food temperatures. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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F 804	Continued From page 39 medication assistant (TMA) stated breakfast on the unit as difficult as the food is dropped off for the residents at various times, there are a lot of residents to feed and to get up by breakfast time. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing stated she had not had any complaints about cold fold; however, food should be the appropriate temperate. A policy regarding food temperatures was not obtained.	F 804		

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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 12/4/24 - 12/6/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 12/27/24

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed H52792043C/MN108549 with no deficiencies issued. The following complaints were reviewed. H52792042C/MN108768 with licensing orders issued at 0535, 0565, 0900, 0920, 1805, and 1810. 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	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 535	MN Rule 4658.0300 Subp. 5 A-D Use of Restraints Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also: A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician; B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and elimination needs; C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and D. release the resident from the restraint as quickly as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop a system to ensure that restrained residents were monitored at the interval specified in the written order from	2 535	F604: Right to be Free from Physical Restraints 1. Nursing leadership will complete updated Physical Device and Restraint	1/24/25

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2 535	Continued From page 3 the physician, assist the resident as often as necessary for safety, comfort, exercise, and elimination needs for not less than ten minutes during each two-hour period in which a restraint is employed and release the resident from the restraint as quickly as possible for 4 of 5 (R4, R5, R6 & R7) residents reviewed for restraints. Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/28/24 indicated R4's Brief Inventory of Mental Status (BIMs) score of 1 indicated severe cognitive impairment. R4 required maximum assistance with personal hygiene, transferring and dressing. R4's pertinent diagnoses were Alzheimer's disease, adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, poor nutrition, inactivity and a decline in physical and mental functioning, pulmonary fibrosis (a lung disease which causes scarring making it difficult to breathe), and hallucinations. R4's physician order dated 10/25/24 indicated R4 used a Broda chair (a specialized wheelchair) with a back latching belt as needed for episodes of increased instability and confusion related to delusions/hallucinations. Staff was to document when using the restraint and document interventions attempted prior to use of the restraint (assist to rest in lounge chair, assist to sit with a snack, offer to lay down). Staff was to assess the need for thigh strap every 30 minutes and release every two hours to offload and reposition R4. R4's care plan dated 11/5/2020 - 12/6/24 indicated R4 used a back latching seat belt on a Broda chair, however the care plan did not	2 535	Assessments for R4, R5, R6, R7, and R8 and revise care plans as needed. Physician orders will be received as needed for anything deemed to be a restraint by 12/30/2024. 2. Any resident with a restraint has the potential to be affected by this deficient practice. All residents who have the potential to be affected will have their most recent Physical Device and Restraint Assessment reviewed and updated as needed, as well as having their care plans updated to reflect any changes. Physician orders will be received for restraints as needed. 3. To ensure systemic changes are sustained, all staff will be provided with education by the Director of Nursing Services or designee on the facility□s policy and procedure titled Restraints, via an in-person meeting by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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2 535	Continued From page 4 identify the belt as a restraint and did not provide interventions for freedom of movement from the restraint following the orders to assessed need every 30 minutes and release every two hours. R4's care plan revision date of 7/14/21 indicated R4 was at risk for falls and had a history of falls related to mental distress, anxiousness and dementia, hallucinations, visuospatial deficient, anxiety, psychosis, altered balance, impaired judgement and incite of safety needs, has history of laying on the floor wandering dystonia, inability to sleep or rest, participate in daily routine, self-injurious behavior, physical ability decline and increased mental distress. R4's interventions were the use of a Broda chair with back latching seat belt as need for periods of increased stability, balance, confusion, delusion/hallucinated objections such as objects on the floor. When increased alertness, resident is able to walk without assistance or device. These interventions related to R4's falls, not the use of the restraint. R4's care plan revision date of 12/12/22 indicated R4 had the potential for pressure ulcer development related to dementia, fluctuation in physical mobility, at times need for Broad chair and rear latching thigh straps, incontinence, and history of ulcer. R4's goal was to have intact skin free of redness, blisters, or discoloration. R4's interviews were to reposition/offload every two hours when in Broda chair. These interventions were related to pressure injuries not the use of the restraints. R4's Physical Device and/or restraint evaluation and review dated 11/27/24 indicated R4 had a specialty wheelchair and a lap/seat belt. The review indicated education was provided with the family of the Broda chair and belt. The chair with	2 535		

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2 535	Continued From page 5 back latching seat was used as needed for periods of increased instability, poor balance, confusion, delusion/hallucination that put resident at risk of falls and injury. When increased alertness and mobility resident is about to walk independently without device. Resident tolerates Broda chair well, does not seem agitated by it. Is able to independently mobilize himself in Broda. Allows resident to rest/mobile safely. Alternatives of decreased stimuli, individual behavior management, medication and clinical review and relaxation techniques were applied. The evaluation did not provide any documentation of interventions for resident to have freedom of movement from the restraints matching the providers orders. R5's physician orders dated 2/3/21 indicated R5 had a Broda chair with a pommel cushion. No interventions for freedom of movement or the medical symptoms intended to treat were provided in the orders. R5's care plan revision date of 8/2/24 indicated R5 was to be up in Broda chair with back latching bilateral thigh belt positioning device. R5 was to be offloaded and repositioning of the thigh belt every two hours. Staff to assist to propel Broda chair. R5's quarterly Minimum Data Set (MDS) dated 10/31/24 indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility.	2 535		

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2 535	Continued From page 6 Upon observation on 12/6/24 at 9:04 a.m. R5 had a thigh belt restraint, not a pommel cushion as the physician orders indicated. R6's signed physician orders dated 10/5/24 -11/5/24 did not indicate R6 used a Broda chair with a pommel cushion, interventions for freedom of movement or symptoms the restraint was intended to treat. R6's Physical Device and/or restraint evaluation and review dated 10/19/24 indicated R6 had a soft helmet. R6's interventions were to release the soft helmet every two hours to offload and reposition. The evaluation did not mention the Broda chair with the pommel cushion. Upon observation on 12/6/24 at 9:04 a.m. R6 was seated in a reclined Broda chair with a pommel cushion between her legs. R7's signed physician order dated 10/5/24 - 11/5/24 did not indicate R7 used a Broad chair with a pommel cushion, interventions for freedom of movement or symptoms the restraint was intended to treat. Upon observation on 12/6/24 at 9:04 a.m. R7 was seated in a reclining Broda chair with a pommel cushion between his legs. R7's Physical Device and/or Restraint evaluation and review dated 9/30/24 indicated R7 had high-low bed, mattress on the floor and a specialty wheelchair (Broda). Informed consent was obtained, however the name of the person who gave informed consent was left blank. Alternative attempts were to decrease stimuli, physical therapy/occupation therapy, and	2 535		

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2 535	Continued From page 7 redirecting. The evaluation did not indicate the devices were a restraint. R7's pommel cushion was not addressed on the evaluation. No interventions were completed and there was no documentation of family/resident education documented. R7's care plan revised date of 12/5/24 indicated Hospice and Occupational therapy were to assist with proper positioning, chair height. Broda chair with pommel cushion for safety. Assist to proper height. Redirect to Broda as able. Trial of the new wheelchair date of 1/2023, consult with hospice. The care plan did not indicate any results or new interventions following the trial from 1/2023. The care plan did not identify any interventions for freedom or movement. R8's care plan revision date of 4/12/23 indicated R8 had a Broda chair with pressure redistribution cushion and self-releasing front latching seat belt. R8's care plan did not indicate interventions for freedom of movement or the symptoms the restraints were indented to treat. R8's signed physician orders dated 10/5/24 - 11/5/24 indicated R8 used a latching seat belt when he was up in his Broda chair. The orders did not indicate interventions for freedom of movement or the medical symptoms the restraint intended to treat. Upon interview on 12/5/24 at 11:48 a.m. the facility Medical Director stated the facility identified during the survey process that they did not have orders for some residents with restraints and he provided those residents with the orders required. The residents he provided orders for during the survey process were not identified. The Medical Director stated he was aware that	2 535		

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2 535	Continued From page 8 assessments, education, consent, least restrictive method, and reassessments are required for restraint use and most of the residents with Huntington's disease used the restraints for repositioning. Upon interview on 12/5/24 at 1:12 p.m. registered nurse (RN)-C stated the residents should be assessed every 30 minutes to see if they still require the use of the restraint if the restraint is being used for behaviors. RN-C stated she was aware there needed to be a reason for the restraint documented, the care plan must have interventions to when to apply or remove the restraint. She was not aware there needed to be a signed physician orders along with facility documentation of what symptoms the restraints were used to treat. Upon interview on 12/6/24 at 2:26 p.m. RN-G stated the staff were to check on the residents with restraints every two hours and staff is to document the restraint checks. RN-G stated R4, R5, R6, and R7 could not remove their restraints themselves. She was not certain if R8 could remove his lap belt himself. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing stated she is officially the infection preventionist and is filling for the DON for a leave, so she was not certain exactly how the facility monitors to make sure the care plans, orders and assessments have all of the required criteria for restraints. A facility policy titled physical restraints/psychotropic medications alternatives dated 4/2/24 identified alternatives to use for physical restraints or psychotropic medications including environmental, physical, equipment and	2 535		

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2 535	Continued From page 9 psychosocial. The policy indicated the risks to residents when a physical restraint is used: falls, accidental death, functional decline, skin breakdown, depression, decreased self-esteem, loss of control, anger, increased agitation, reduced appetite, decreased quality of life, power issues, family stress, loss of dignity, reduced bone mass, loss of muscle tone, strangling, suffocation, bruising, cuts scrapes, feeling of isolation and entrapment. The facility provided a bed assessment and side rail safety, focused audit with a revision date of 9/17/24. The policy was not specific to the use of restraints. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 535		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	2 565	F656: Develop/Implement Comprehensive	1/24/25

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2 565	Continued From page 10 review the facility failed to implement the person-centered care plan for 2 of 4 residents (R5 and R7) reviewed to meet the resident's needs. In addition, the facility failed to complete a person-centered care plan for 2 of 4 residents (R4 and R6) to describe the residents medical needs. Findings include: R4's quarterly Minimum Data Set (MDS) dated 11/28/24 indicated R4's Brief Inventory of Mental Status (BIMs) score of 1 indicated severe cognitive impairment. R4 required maximum assistance with personal hygiene, transferring and dressing. R4's pertinent diagnoses were Alzheimer's disease, adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, poor nutrition, inactivity and a decline in physical and mental functioning, pulmonary fibrosis (a lung disease which causes scarring making it difficult to breathe), and hallucinations. R4's physician order dated 10/25/24 indicated R4 used a Broda chair (a medical device chair that provides comfort and support) with back latching belt as needed for episodes of increased instability and confusion related to delusions/hallucinations. Staff was to document when using the restraint and document interventions document interventions attempted prior to use of the restraint (assist to rest in lounge chair, assist to sit with a snack, offer to lay down). Assess need for thigh strap every 30 minutes and release every two hours to offload and reposition R4. R4's care plan dated 11/5/2020 - 12/6/24 did not indicate R4 was to be assessed every 30 minutes	2 565	Care Plan 1. Nursing leadership will review the care plans of R4 and R6 to ensure they remain accurate and appropriate. This review will be completed by 12/30/2024. 2. All residents who use restraints have the potential to be affected by this deficient practice. Nursing leadership will review the care plans of all residents with restraints to ensure they remain accurate and appropriate. This review will be completed by 12/30/2024. 3. To ensure systemic changes are sustained, all nursing staff will be provided education by the Director of Nursing Services or designee on Restraints and the importance of following care planned interventions for all residents. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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2 565	Continued From page 11 for the thigh strap and release every two hours to offload and reposition. R5's care plan intervention revision date of 12/12/23 indicated R5 was unsafe to use the toilet, staff was to check and change her incontinent brief every two hours and assist with bowel movements as needed. R5's care plan intervention revision date of 8/2/24 indicated R5 was to be up in Broda chair with back latching bilateral thigh belt positioning device. Offload and reposition thigh belt every two hours. Staff was to assist R5 to propel Broda chair. R5's care plan intervention dated 7/24/24 indicated R5 was to be turned/repositioned every two hours due to potential for pressure ulcers related to incontinence. R5's care plan dated 9/19/24 indicated R5 was to be kept in the common area as resident allows when up in her Broda chair due to falls. R5's quarterly Minimum Data Set (MDS) dated 10/31/24 indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility. Upon continuous observation on 12/6/24 at 8:41 a.m. R5 was seated in her Broda chair with the trunk restrain buckled over her thighs. R5 completed breakfast at 9:20 a.m. R5 was taken to	2 565		

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2 565	Continued From page 12 her room by NA-C. R5 was in her Broda wheelchair with truck restraints (a padded cushion with a belt secured between the thighs of a patient in the Broda chair) on her lower extremities. R5 was not checked until 11:37 a.m. when NA-C checked on R5 and asked her if she want to lay down, R5 was still in her Broda chair with her trunk restraints on. R5 was not repositioned, her incontinent brief was not checked or changed, and was not asked if she wanted to be in her room or in the common areas indicated for safety as her care plan indicated. R6's Physical Device and/or restraint evaluation and review dated 10/19/24 indicated R6 had a soft helmet. R6's interventions were to release the soft helmet every two hours to offload and reposition. The evaluation did not indicate any interventions for the Broda chair reclined with the pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart), which R6 was using. R6's MDS dated 10/24/24 indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. Upon continuous observation R6 was taken to her room by TMA-A at 9:29 a.m. R6 was in her wheelchair in a reclined position with a pommel cushion (a wheelchair cushion with a raised center section that keeps the knees apart) in place. R6's call light was laying on top of her bed. At 10:34 a Hospice nursing assistant (NA)-D came to visit and provide cares for R6. A hospice Registered nurse (RN)-F visited R6 at 11:30 a.m. and seated R6 at her lunch table in the commons area. Facility staff had not checked on R6 since	2 565		

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2 565	Continued From page 13 leaving her in her room at 9:29 a.m. R6 was not checked on as her care by facility staff every two hours as indicated. R7's significant change (MDS) dated 7/25/24 indicated R7's Brief Inventory of Mental Status (BIMs) of 3 indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and bladder. R7's pertinent diagnose was Huntington's disease. R7's care plan with a revision date of 6/13/24 indicated R7 was to remind/assist to turn and reposition every two hours. Encourage R7 to lay down after means due to history of stage two pressure ulcers on buttocks. R7's care plan with a revision date of 9/20/24 indicated R7's incontinent brief was to be checked and changed every two hours and as needed. Staff was to apply barrier cream at least once per shift due to pressure ulcers. Upon continuous observation on 12/6/24 at 8:41 a.m. R7 was seated in his Broda chair with his pommel cushion between his legs. At 9:31 a.m. NA-C took R7 to his room. R7 was still seated in his reclined wheelchair with a pommel cushion between his legs. R7 was placed next to his bed facing his television. R7 was not checked on again until 11:40 a.m. when NA-C went into his room and changed his incontinent brief by laying him on his bed for a few minutes and then standing him by the toilet to change the pad. He was then sat back in the Broda with the pommel at 11:46 a.m. R7 was not offered a position	2 565		

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2 565	Continued From page 14 change or asked if he wanted to lay down until 11:40 a.m. R8's care plan dated 7/28/11 - 12/5/24 did not indicate R8 had a Broda chair with a front latching seat belt or any parameters or interventions for the use. R8's quarterly MDS dated 10/10/24 indicated R8 had a BIMs score of 11 indicating moderate cognitive impairment. R8 was always incontinent of bowel and bladder. R8 required moderate assistance of staff for activities of daily living and transferring. Upon observation on 12/5/24 at 2:50 p.m. R8 was observed in a Broda chair with a front latching seat belt. Upon interview on 12/6/24 at 11:36 a.m. nursing assistant (NA)-C stated she did not ask R7 if he wanted to lay down after breakfast because he never stays in bed and his care plan should not say that. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing (DON) stated her expectation is that the care is followed and is person-centered to and up to date. A facility policy titled Care Plans with a revision date of 12/2/24 indicated the comprehensive care plan includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary,	2 565		

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2 565	Continued From page 15 educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess and initiate interventions to minimize the risk for pressure ulcer development for 1 of 3 residents (R1) reviewed. R1 was harmed when R1 developed avoidable pressure ulcers. Findings include: According to the State Operations Manual,	2 900	F686: Treatment/Services to Prevent/Heal Pressure Ulcers 1. R1□s care plan included interventions related to prevention and treatment of pressure ulcers. R1 no longer resides at the facility. 2. All residents with a Braden Score of 18 or less have the potential to be affected by this deficient practice. Nursing leadership or designee will complete	1/24/25

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2 900	Continued From page 16 Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, indicated: -"Pressure Ulcer/Injury (PU/PI)" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. - "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. -Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). -Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The	2 900	updated skin checks to ensure there are no unidentified skin concerns on or before 12/30/2024. Care plans will be updated as appropriate. 3. To ensure systemic changes are sustained, all nursing staff will be provided education by the Director of Nursing Services or designee on the facility□s policy and procedure Skin assessment Pressure Ulcer and Documentation. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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2 900	Continued From page 17 wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). R1's care plan dated 10/19/24 indicated R1 had a potential for pressure ulcer development due to dementia, incontinence, refusal of cares and for assistance with mobility. R1's goal was to have intact skin, free or redness, blisters, or discoloration. R1's interventions were to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc. noted during baths or daily care and to explain and reinforce to resident the importance of adequate intake. The care plan identified on 10/21/24 R1 had inadequate protein-energy intake related to poor appetite as evidenced by consuming less than 50% of meals and weight loss greater than 5% in less than 30 days. R1's care plan failed to incorporate interventions to prevent the development of pressure ulcers. R1's dietary assessment dated 10/21/24 indicated R1 had significant weight loss of 5% in 30 days. R1 was at risk for malnutrition, weight loss, reduced muscle mass. R1 had inadequate protein intake and a Braden skin assessment score of 15 upon admission. R1's quarterly Minimum Data Set (MDS) dated 11/6/24 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 5 indicating he was	2 900		

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2 900	Continued From page 18 severely cognitively impaired. R1 did not have behaviors or refusal of cares. R1 required extensive assistance with bed mobility, transfers, eating, and toilet use. R1's pertinent diagnosis was Parkinson's disease. R1 had no pressure ulcers. R1 was not receiving any skin and ulcer/treatments. R1's skin assessment dated 11/26/24 indicated R1 had dry skin, but no bruising, abrasions, skin tears, rash, or pressure injuries. R1's Braden Scale for Predicting Pressure risk (admission/readmission) dated 11/27/24 indicated R1 had a score of 16 and was at mild risk for pressure ulcer. A score of 15-18 indicated R1 was a mild risk. Mild risk interventions guideline included: -Frequent turning every two hours. -Maximal remobilization -Protect heels. -Manage moisture, nutrition, friction, and shearing. -If other major risk factors present (advanced age, poor dietary intake of protein, diastolic blood pressure below 60, hemodynamic instability) (the body cannot maintain consistent blood flow and pressure), advance to the next level of risk. R1's skin assessment dated 11/28/24, indicated R1 had a right hip moisture associated skin damage (MASD) stage 1 pressure ulcer (intact skin with a localized area of non-blanchable redness) 9x13 centimeters (cm), barrier cream and foam dressing applied. R1's family, primary care provider and the nurse manager were notified. R1's care plan revision date of 11/29/24 indicated the resident had potential for impairment to skin	2 900		

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2 900	Continued From page 19 integrity related to thin and fragile skin of the right hip. R1's goal was to be free from skin injury through the review date of 1/18/25. R1's interventions were to monitor the location, size, and treatment of the skin injury. Report abnormalities, failure to heal, s/s of infection, maceration etc. to the health care provider. Identify potential causative factors and eliminate/resolve where possible. Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short. The care plan did not identify that R1 had acquired an actual pressure ulcer nor the treatment for the pressure ulcer. The care plan did not include any additional interventions. R1's nursing progress note dated 11/29/24 at 1:05 p.m. indicated the R1's nurse practitioner (NP) was left a message updating her on R1's right hip ulcer requesting treatment. R1's nursing progress note dated 11/29/24 at 9:42 p.m. indicated NP would see R1 Monday (12/2/24) before referring R1 to the wound provider. No orders were provided. R1's electronic treatment administration record (eTAR) dated 11/29/24 indicated a nursing order was placed to cleanse area on right hip daily, pat dry and apply foam dressing to area. The order was placed on hold from 11/29/24 to 12/1/24. No other treatment orders for the wound were on the eTAR. R1's hospital admission note dated 11/29/24 at 10:30 p.m. indicated: -R1 had a pressure injury to his right toe. -R1 had a pressure injury or blanchable erythema middle sacrum, -R1 had a pressure injury Stage 2 to the right hip	2 900		

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2 900	Continued From page 20 (a partial thickness loss of the skin, appearing as a shallow open sore or blister, where the top layer of skin and potentially the deeper layer are damaged resulting in a visible wound. -No other information was documented. R1's hospital Braden score dated 11/29/24 indicated R1 had a Braden score of 12 indicating R1 was at a moderate risk for developing pressure ulcers. R1's care progression note dated 12/2/24 indicated R1 was on comfort cares. R1 moaned and groaned with turns as right hip was tender from pressure injury, dressing was changed as needed. R1's palliative care encounter note dated 12/2/24 indicated family explained to the provider R1 was neglected at the facility which resulted in the pressure sores and poor nutrition. He began to decline at the facility eventually not eating independently, lying in bed most of the time and less responsive to staff and family. Upon interview on 12/4/24 at 12:18 p.m. nursing assistant (NA)-A stated on 11/28/24 she found redness on R1's right hip and reported it to the nurse immediately. She stated it was a large triangle area over the bone with tinged blood. She stated it looked like he had "laid on it a long time." She did notice redness on R1's coccyx, stating it did not have blood like his hip and that it did not need to be reported to the nurse because the NAs could use cream on the coccyx. NA-stated she did not notice any skin concerns with R1's feet. NA-A stated she was never told to reposition R1 when he was in bed or use any heel protectors.	2 900		

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2 900	Continued From page 21 Upon interview on 12/4/24 at 12:40 p.m. registered nurse, (RN)-A stated he was the nurse who sent R1 to the hospital on 11/29/24. He was not aware of any skin concerns with R1. He stated there were not treatments ordered, no staff mentioned any skin concerns to him, and it was not R1's day for a skin assessment. Upon interview on 12/4/24 at 2:52 p.m. RN-B stated she was a float nurse and was the nurse who NA-A reported R1 had a pressure ulcer on his right hip. She stated his hip appeared to have a large upside-down triangle on it over his bony prominence. The skin was intact. R1 tended to lay on his right side often. RN-B stated she put barrier cream on the pressure ulcer and covered it with a dressing. She notified the family, the nurse manager, and the nurse practitioner. She did not follow-up to see R1 had received any skin care orders. Email correspondence on 12/5/24 at 7:42 a.m. from R1's family member (FM)-A revealed seven photos taken on 11/29/24 at approximately 7:00 p.m. in the hospital emergency room. Image 1 revealed a red, raised area on the anterior midsection of R1's right foot. Image 2 revealed bilateral redness and peeling of the skin on R1's buttock from the top of the intergluteal crease to below the sacrum into the gluteal folds. The redness covers one-half of the gluteus maximus bilaterally. Skin appeared dry. Inside the gluteal fold could not be observed. Image 3 and 4 revealed rightness over R1's entire right heel and redness on the bony prominence posterior to the right big toe. R1's foot appeared excessively dry. Image 5 and 7 revealed a blister, full eschar (scab) over the medial bony prominence of R1's	2 900		

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2 900	Continued From page 22 right big toe. Image 6 revealed a raised, red area with three-quarters of the area open and appeared to have serosanguinous (blood and serum fluid from the wound) drainage, well defined edges. Peeling of the epidermis noted on the anterior and posterior part of the wound. Surrounding skin appeared dry. Upon interview on 12/5/24 at 12:12 p.m. the facilities Medical Director stated on the admission the facility completes a full skin assessment and then on a weekly basis the day resident's shower. He stated "it depends" if weekly skin assessments are enough stating it would be the nurse's judgement such as mobility, nutrition, diagnosis, etc. He stated skin breakdown can occur quickly for instance if a resident is septic (blood infection) or someone with vascular problems skin conditions can change within hours especially in the lower extremities (legs and feet). He stated in very debilitated residents the skin can change from one week to another. Regarding R1's coccyx pressure ulcer the NAs should have noticed that when they were changing R1's incontinent briefs. Upon interview on 12/5/24 at 1:12 p.m. RN-C the nurse manager stated she was aware of R1's wound. She stated the wound happened on a holiday 11/28/24 and was aware the NP would see R1 on the following Monday 12/2/24 however, R1 was transferred to the hospital on 11/29/24. RN-C stated she would have guessed R1 would have had a low Braden score and was surprised it was a 16. She stated he was admitted following significant weight loss, was incontinent of bowel and bladder, had dementia and was chair bound. She stated with a lower Braden score R1 would have had more	2 900		

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2 900	Continued From page 23 interventions. RN-C did not elaborate on what more interventions could have been place. RN-C was shown pictures taken with permission of R1's family in the emergency room and stated the staff should not have missed those pressure ulcers. Upon interview on 12/6/24 at 4:30 p.m. R1's NP stated she recalled being called about "redness" on R1's hip measuring 9 x 13 cm. She stated she told the facility she would look at on 12/2/24 on her rounds. She stated she would have expected the facility to keep it covered, use barrier cream, assess, and turn and reposition him until then. She stated she was not informed of any other skin concerns for R1. She stated she read R1's hospital notes and the documented pressure ulcers and stated the facility should have caught those as those type of wounds would not have happened within hours during the transfer from the facility to the hospital. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated the facility has skin assessments in place on admission and weekly thereafter. She stated the NAs are trained to notify the nurse with any skin changes and did notify the nurse with R1's hip pressure ulcer. She stated the facility staged the ulcer at a one and they should have been providing care there. She stated R1's other skin altercations should be noticed at the facility. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation Requirements with a revision date of 4/26/24 indicated all residents will be identified for their risk of developing pressure ulcers on admission/readmission by a registered nurse using the Braden Scale predicting pressure risk UDA. Those residents determined to be at risk	2 900		

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2 900	Continued From page 24 will have the Braden scale completed weekly for the first four weeks. A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant is responsible for this and will report any abnormal findings or signs of skin impairment to the licensed nurse. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide 1 of 3 residents (R3) reviewed who was unable to carry out activities of daily living (ADL's) the necessary services to maintain proper personal hygiene. Findings include:	2 920	F677: ADL Care Provided for Dependent Residents 1. Nursing leadership will review R3□s care plan to ensure appropriate interventions are in place for ADL care. This review will be completed by 12/30/2024. 2. All residents who are dependent on	1/24/25

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2 920	Continued From page 25 A facility grievance log dated 8/23/24 indicated R3 had complaints regarding cares indicating a resolution date of 9/12/24. No further documentation was provided upon request. A facility grievance log dated 10/8/24 indicated R3 had complaints regarding cares with a resolution date of 10/28/24. No further documentation was provided upon request. R3's physician orders dated 10/22/24 indicated to keep peri area clean and dry every shift. R3's hospital discharge summary dated 11/10/24 indicated R3 was septic due to catheter related urinary tract infection. R3 was discharged back to the facility on 11/15/24. R3's care plan revision dated 11/15/24 indicated R3 had an ADL self-care performance deficit related to central cord syndrome at C5 (spinal cord injury which the spinal cords ability to transmit messages from the brain), post-traumatic stress disorder, gastric bypass for obesity, fibromyalgia (body pain and tiredness), sepsis due to catheter related urinary tract infections, cough with atelectasis (collapse of part of the lung), and fatigue needs assistance with ADLs. R3's goals were to improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. Interventions were: Personal hygiene resident required one staff maximum assist. Two staff as able for perineal care. Toilet use resident required two staff maximum assistance check and change every two hours. Catheter care by nursing assistant twice daily. R3's re-admission MDS dated 11/21/24 indicated	2 920	staff for ADL care have the potential to be affected by this deficient practice. Nursing leadership will review the care plans of the residents who are dependent on staff for ADL care to ensure that appropriate interventions are in place. This review will be completed by 12/30/2024. 3. To ensure systemic changes are sustained, education on the facilities policy and procedure Perineal Care will be provided to all nursing staff. This education will be provided by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance date 1/24/2025.	

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	00890	A. BUILDING: _____ B. WING _____	C 12/06/2024

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2 920	Continued From page 26 R3's BIMs score was a 15 indicating R3 was cognitively intact. R3's was assessed and did not have any behaviors or rejection of cares. R3 was totally dependent on staff for toileting hygiene and lower body dressing. R3 required extensive assistance with transferring, rolling left and right, and upper body dressing. R3 had an indwelling urinary catheter. R3 was frequently incontinent of bowel. R3's pertinent diagnoses were encounter for orthopedic aftercare, central cord syndrome at C5, spinal stenosis cervical region (spaces in the backbone become too small causing pressure), spondylosis cervical region (wear and tear of the spine), weakness, and morbid obesity. Upon interview on 12/5/24 at 9:01 a.m. registered nurse (RN)-E stated R3 had made multiple complaints to the facility. She stated she recalled one complaint about call lights and R3 was given a highly sensitive button to push. She stated she could not recall the other complaints but would provide the documentation to the surveyor. Upon observation and interview on 12/5/24 at 12:20 p.m. R3 stated the concern she had was staff was not cleaning her peri-area appropriately or not at all and she has been in the hospital recently for a urinary tract infection. She stated she had made complaints to the facility and was told staff had been educated about the need to properly clean her. R3 stated she was educated in the hospital about the importance of making sure her peri-area is kept clean and dry. R3 stated earlier on 12/5/24 nursing assistant (NA)-B came into the room, got a washcloth wet and handed it to R3 to wash her face. R3 stated peri-care was not completed and her catheter bag had not been emptied. R3 pressed her call light and trained medication assistant (TMA)-B answered the light and emptied her catheter bag	2 920		

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2 920	Continued From page 27 upon her request R3 had 1700 cubic centimeters (cc) of urine in the bag. TMA-B apologized for the bag not being emptied sooner. R3 told TMA-B that the surveyor would like to visualize her wounds, so a time was set-up for 1:30 p.m. on 12/5/24. Upon observation and interview on 12/5/24 at 1:45 p.m. RN-D, NA-B and an unidentified NA turned R3 onto her left side. R3's incontinent pad was dry and no odors present. R3 asked NA-C to please clean her up since she had only handed her a wash clothing for her face in the morning. NA-C stated she was going to go back complete peri-care for R3 but had not had time. The staff positioned R3 on her back. NA-C filed a basis with soap and water. NA-C cleansed between R3's labial folds and along the catheter tubing with the first wash cloth, there was dried blood and dried feces on the washcloth. NA-C used a second washcloth and wiped away again dried feces. The staff again placed R3 on her left side and NA-C used a third washcloth and wiped away a small amount of soft feces. A fourth washcloth was used and wiped away a small amount of soft feces in the buttock crease. NA-C then took a wet wipe and cleaned the rest of R3's buttocks. RN-D stated to NA-C R3 should have been cleaned-up in the morning to be kept clean and dry. Upon interview on 12/5/24 at 2:12 p.m. NA-C stated she was going back to clean-up R3 but had not had time. In addition, she stated R7 refuses cares often. She denied reporting to nursing staff or trying to get assistance from other staff. Upon interview on 12/6/24 at 2:54 p.m. the director of nursing stated R3 had been	2 920		

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2 920	Continued From page 28 hospitalized multiple times with urinary tract infections. She stated R3 refuses cares often, but staff were able to properly clean her. A facility policy on activities of daily living for dependent residents was requested and not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 920		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to treat with dignity for 1 of 3 residents (R7) reviewed for resident rights. A nursing assistant (NA)-C was observed speaking to R7 in a belittling manner while providing cares. Findings include: R7's significant change Minimum Data Set (MDS)	21805	F550: Resident Rights/Exercise of Rights 1. Immediate re-education was provided to the staff member providing care to R7 prior to survey exit. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, all staff will be provided with education on treating residents with dignity	1/24/25

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21805	Continued From page 29 dated 7/25/24 indicated R7 had unclear speech, slurred or mumbled words. R7 could usually make himself understood. R7 did not have difficulty understanding others. R7's Brief Inventory of Mental Status (BIMs) of three indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and urine. R7's pertinent diagnoses were Huntington's disease (an inherited disease where the nerve cells in the brain break down), dysphagia (difficulty swallowing foods), and dorsalgia (back pain). Upon observation and interview on 12/6/24 at 11:40 a.m. nursing assistant (NA)-C went into R7's room to check on him. R7 was seated in his wheelchair reclined with his pommel restraint in place (a wheelchair cushion with a raised center section that keep the knees apart). NA-C walked in the room and said, "What the hell?" She noticed surveyor was observing and stated she was talking about the soap opera on his television on how in the hell the actors look like they did 30 years ago. NA-C asked R7 if he wanted to lay down. He shook his head and stated yes. She assisted him to his bed. His arms and legs were flailing when he was on his back in his bed. NA-C looked at surveyor and stated look how difficult he was to take care of with his movements. NA-C noticed R7's incontinence brief was wet along with the shorts he was wearing. NA-C placed clean shorts on him while he was on the bed. She was unable to change his brief on his bed due to his movements. NA-C told R7 she would have to take him in the bathroom to change his brief, he nodded yes. She stood him	21805	and respect via the success center and an in-person meeting by 1/24/2025. The meeting will be conducted by the Director of Nursing Services or designee. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance Date ¿¿¿¿1/24/2025.	

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21805	Continued From page 30 up, sat him down in his wheelchair, wheeled him to the bathroom, stood him up by the toilet so he could hold onto handrails. NA-C pulled R7's shorts down and removed his brief at which point he passed gas. NA-C in a harsh tone said "seriously" and used his name. NA-C cleaned him with a wet wipe and placed a clean brief on him and sat him back in his chair. When asked her about her comments after he passed gas NA-C stated she was just joking around with him, and he knew that. Upon interview on 12/6/24 at 11:46 a.m. R7 was asked using yes and no questions during the interview due to his aphasia (inability to communicate due to Huntington's disease) if NA-C was rough with him during the transfer process and he said "no." R7 was asked if he thought NA-C spoke kindly to him and he stated "No" and then said "I can't help how I am." R7 was asked if he felt that what NA-C said was verbal abuse and he stated "yes." Upon interview on 12/6/24 at 2:54 p.m. the director of nursing (DON) stated she spoke with NA-C was told by NA-C that she was just joking around with R7. The DON provided immediate education to NA-C regarding treatment of residents and appropriate communication. The DON stated registered nurse, (RN)-C, spoke with R7 and R7 had no concerns about NA-C providing care to him. Upon interview on 12/6/24 at 3:09 p.m. RN-C stated she spoke with R7, and he told her he was not uncomfortable with NA-C's comments, and he was comfortable working with her. A policy regarding dignity was not obtained.	21805		

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21805	Continued From page 31 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights, or another means to request assistance were accessible for 4 of 4 residents (R5, R6, R7, and R8) reviewed who were dependent on staff for mobility. Findings include: R5's care plan revision date of 10/23/24 indicated to keep call light and television remote in place especially when R5 was in bed due to falls.	21810	F558: Reasonable Accommodations Needs/Preferences 1. R5, R6, R7, R8 were assessed for their ability to use their call light appropriately. Their care plans were updated with appropriate interventions as needed by 12/27/2024. 2. All residents who are dependent on staff for mobility have the potential to be affected by this deficient practice. A review of all residents who are dependent on staff for mobility will be completed to ensure appropriate interventions are in	1/24/25

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21810	Continued From page 32 R5's quarterly Minimum Data Set (MDS) dated 10/31/24 indicated R5 had a Brief Inventory of Mental Status of zero indicating severe cognitive impairment. R5 was totally dependent on staff for eating, oral and toileting hygiene, dressing and transferring. R5 was always incontinent of bowel and bladder. R5's pertinent diagnosis was Huntington's disease (an inherited disease in which nerve cells break down over time.) R5 had falls in the facility. Upon continuous observation on 12/6/24 at 9:14 a.m. R5 completed breakfast at 9:20 a.m. R5 was taken to her room by NA-C. R5 was in her Broda wheelchair (a medical device chair that provides comfort and support) with truck restraints (a padded cushion with a belt secured between the thighs of a patient in the Broda chair) on her lower extremities. R5 did not have a call light in place, the light was hanging on the wall. R5 was checked at 11:37 a.m. when NA-C checked on R5 and asked her if she wanted to lay down. R5 said "no." NA-C left the room without placing the call light within R5's reach. R6's MDS dated 10/24/24 indicated R6 had a BIMS score of 11 indicating cognitive impairment. R6 was dependent upon staff for oral and toileting hygiene, dressing and transferring. R6 was always incontinent of bowel and bladder. R6's pertinent diagnosis was Huntington's disease. R6's care plan dated 10/26/24 did not indicate the use of a call light or how R6 was to notify staff when assistance was needed. Upon continuous observation on 12/6/24 at 9:29 a.m. R6 was taken to her room by TMA-A. R6 was in her wheelchair in a reclined position with a pommel cushion (a wheelchair cushion with a	21810	place by 12/30/2024. 3. To ensure systemic changes are sustained, all staff will be provided with education on the importance of keeping the resident□s call light accessible to them. This education will be provided by the Director of Nursing Services or designee via an in-person meeting by 1/24/2025. 4. To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 for 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5. Compliance Date 1/24/2025.	

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21810	Continued From page 33 raised center section that keeps the knees apart) in place. R6's call light was laying on top of her bed. At 10:34 a Hospice nursing assistant (NA)-D came to visit and provide cares. A hospice Registered nurse (RN)-F visited R6 at 11:30 a.m. and seated R6 at her lunch table in the commons area. Facility staff had not checked on R6 since leaving her in her room at 9:29 a.m. without her call light in place. R7's significant change (MDS) dated 7/25/24 indicated R7's Brief Inventory of Mental Status (BIMs) of 3 indicating R7 was severely cognitively impaired. R7 was totally dependent on staff for eating, oral hygiene, toileting hygiene, showers, and dressing. R7 required extensive assistance with rolling left and right sitting to lying and sit to stand transfers. R7 was always incontinent of bowel and bladder. R7's pertinent diagnose was Huntington's disease. R7's care plan dated 8/14/24 did not indicate the use of a call light or how R7 was to notify staff when assistance was needed. Upon continuous observation on 12/6/24 at 9:31 a.m. NA-C took R7 to his room. R7 was in a reclined wheelchair with a pommel cushion between his legs. R7 was placed next to his bed facing his television. R7's call light was hanging on his wall. R7 was not checked on again until 11:40 a.m. when NA-C went into his room and changed his incontinent brief. NA-C left his room at 11:44 leaving him in his chair without his call light within reach. R8's care plan dated 8/14/24 did not indicate the use of a call light or how R5 was to notify staff when he needed assistance, or another means to notify staff when assistance was needed.	21810		

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21810	Continued From page 34 R8's quarterly MDS dated 10/10/24 indicated R8 had a BIMs score of 11 indicating moderate cognitive impairment. R8 was always incontinent of bowel and bladder. R8 required moderate assistance of staff for activities of daily living and transferring. Upon continuous observation on 12/6/24 at 9:36 R8 was in his room with the door closed. R8 was in a wheelchair asleep approximately 10 feet from his bed. His call light was on the floor next to his bed. At 9:36 a.m. TMA-A checked on R8 and was heard saying to a nursing assistant that R8 was still asleep he will get breakfast later. Call light was still on the floor and R8 had not moved in his wheelchair. At 10:31 a.m. TMA-A had again checked on R8, and he was still asleep in his wheelchair in the same position. The call was placed on the bed as the bed was made. R8 was still in his room at 11:50 when the surveyor left the unit. Upon interview and observation on 12/6/24 at 11:35 a.m. NA-C stated that none of the residents can use the call light on the unit. She stated that is why they are checked on every two hours. She then stood up from the desk and went and checked on R5. Upon interview on 12/6/24 at 2:15 p.m. trained medication assistant (TMA)-A stated R5, R6, R7 and R8 are all able to use their call lights, however they do not use them that is why staff forget to place the call lights within reach. He was not certain if call lights were on the care plans. TMA-A stated all the residents are checked on every two hours.	21810		

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21810	Continued From page 35 Upon interview on 12/6/24 at 2:26 p.m. RN-G stated R5 is not able to use a call light, her hands cannot function well enough to do so. R5 was supposed to be in the common area and not left alone in her room as she has tipped herself over in her wheelchair chair. R6 can use the call light as RN-G has seen her use it. R7 could use the call light if it were placed with him when he is seated in his chair in his room. R8 was able to use his call light. Upon interview on 12/6/24 at 2:52 p.m. the director of nursing, DON stated call lights are a standard of practice and are not on the care plan and they should always be in reach for the resident's use. The DON was not certain if R5, R6, R7, or R8 were able to use the call light. She stated staff are to check on the residents frequently. She did not clarify how frequent, stating "depending on the resident." A facility policy titled Call Light with a revision date of 7/29/24 indicated the purpose was to ensure resident always had a method of calling for assistance. Staff was to place the call light within easy reach of the resident when leaving the room. For residents who are unable to use a call light, care plan appropriate interventions and provide adequate call light if applicable. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21810		

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