DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 26, 2021

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

RE: CCN: 245337
Cycle Start Date: March 18, 2021

Dear Administrator:

On April 26, 2021, we notified you a remedy was imposed. On May 24, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 19, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 8, 2021, 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 April 8, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 19, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
April 8, 2021

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

RE: CCN: 245337
Cycle Start Date: March 18, 2021

Dear Administrator:

On March 18, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 June 18, 2021 (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 September 18, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING _____ B. WING _____	C 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LINDEN LLC	**105 WEST LINDEN STREET STILLWATER, MN 55082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/17/21, through 3/18/21, an abbreviated survey was completed at your facility to conduct a complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5337049C (MN70970). H5337048C (MN64254) unsubstantiated, but identified related incidental findings and cited at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		4/28/21

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

Electronically Signed | 04/15/2021

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

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the administrator and State agency (SA) were notified within 24 hours of allegations of neglect, for 1 of 3 residents (R2) reviewed for allegations of abuse, neglect and injuries of unknown origin. Findings include: R2's face sheet printed 3/19/21 indicated diagnosis included paralytic syndrome (episodes of muscle weakness or paralysis) and dementia. R2's care plan dated 1/16/19, indicated R2 required a maxi lift and assist of two for transfers. R2's progress note dated 8/8/20, at 6:59 p.m. indicated, "CNA summoned writer to resident's room. Maxi lift tipped over during res transfers.	F 609	- How corrective action will be accomplished for those residents found to have been affected by the deficient practice. - At the time of the incident on 8/8/20, the facility completed a risk management and post-incident review to determine the cause of contributing factors to the avoidable accident. The facility put corrective measures in place following the incident including reassessment of resident lift status and care plan revision. Staff were re-educated on mechanical lifts following the incident. R2 discharged (unrelated from the incident) from the facility 11/08/2020. - How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 609	Continued From page 2 Hoyer tipped over after res was lowered to wheelchair, no injuries observed. Maxi lift did not hit resident. Resident denies pain as result of incident. will continue to monitor." R2's progress note dated 8/10/20, at 3:42 p.m. indicated, Resident had maxi lift tip over during a transfer from bed to wheelchair. Staff and agency aide were working together on the transfer and thought the legs of the lift were left closed while the resident was push/pulled into place over his wheelchair causing it to tip onto the ground with him attached to it. Neither resident nor staff were injured in the incident. DON, MD, and resident's sister informed of the incident. Staff will be reeducated on use of the maxi lift. Incident Review and Analysis dated 8/11/20, indicated, Staff misused lift equipment (not opening the legs of the Invacare maxi lift during a transfer) and pulled on resident while suspended in sling causing center of gravity to shift and machine to tip onto the ground. Resident was lowered to wheelchair without injury despite still being connected to the lift as it fell. Staff responsible for correct use of equipment, resident diagnoses did not play a role in incident. Education provided for all nursing department staff. Aides who failed to operate equipment correctly reassessed for competency in use of mechanical lift skill. R2's Pain Evaluation dated 8/11/20, indicated R2 reported occasional, moderate pain within last 5 days and was given Tylenol 1000 mg (milligrams) each morning which was effective. When interviewed on 3/18/21, at 8:15 a.m. the director of nursing (DON) verified the incident had	F 609	- QAPI team reviewed all incidents/accidents reports for December 2020 to present to identify any incidents that may require reporting to the state agency. - The facility has a policy and procedure titled Abuse Prohibition/Vulnerable Adult Plan which includes a procedure for notifying the administrator and state agency of alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The policy and procedure does address avoidable accidents and remains current. - What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. - All staff will be educated on completing risk management/incident reports for accidents and to notify the Administrator via the chain of command according to the Abuse Prohibition/Vulnerable Adult Plan which includes a procedure for notifying the administrator and state agency of alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and	

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F 609	Continued From page 3 occurred and stated, "there was an issue with the legs of the lifts." DON stated they facility had considered reporting the incident but did not as R2 did not sustain an injury. Even though R2 had received tylenol daily for five days after the incident occurred. When interviewed on 3/18/21, at 12:23 p.m. nursing assistant (NA)-E verified on 8/8/20, while she and NA-G transferred R2, the hoyer lift tipped over onto R2. NA-E stated she believed the incident was caused by "an operator error" and she felt NA-G "didn't really know how to maneuver [R2]" so she explained the use of the lift to NA-G during the transfer. NA-E stated NA-G was operating the lift and failed to open the legs of the lift, causing R2's weight to shift and the lift 'tipped over" towards R2, causing him to fall into his wheelchair. NA-E stated she did not think the lift landed on R2 and she did not believe R2 "hit anything hard." NA-E stated NA-G went to get licensed practical nurse (LPN)-C to assess R2 who was not complaining of pain at that time and appeared to be "in shock." NA-E stated the facility "assessed us every so often for lift use before the incident." NA-E verified she received post-incident reeducation on lift use. When interviewed on 3/18/21, at 1:34 p.m. LPN-C verified the incident had occurred and stated he did not remember any further details other than what he had written in the progress notes. When interviewed on 3/18/21, at 3:16 p.m. DON asked to verify if the concerns with R2 surrounded the incident not being reported and verified she understood the lack of education and operational error on behalf of staff precipitating	F 609	misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury - The Administrator and Director of Nursing will review and sign education for The Abuse Prohibition/Vulnerable Adult Plan which includes a procedure for notifying the administrator and state agency of alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury - The facility has a morning start up process where all incidents/accidents are discussed to identify any incidents that may require reporting to the state agency. The facility maintains an after-hours protocol for reporting incidents to the administrator via the chain of command and have the resources to file a nursing home online incident report with MDH/OHFC. - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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F 609	Continued From page 4 the incident. A facility form titled, Mechanical Lifts, indicated NA-E received education on use of lifts including a demonstration on 12/17/19, and education on Mechanical Lifts/Sit-to Stand lifts including a demonstration on 8/7/20, one day before the event occurred. There was no indication that NA-G had received any education on lifts prior to the incident occurring. Facility document titled Mechanical Lifts, dated 8/9/20, indicated NA-E and NA-G were reeducated on the use of lifts on this date. Facility policy titled Abuse Prohibition/Vulnerable Adult Plan, dated 7/5/19, directed Incidents that must be reported to MDH include: Avoidable Accidents: Means that an accident occurred because the facility failed to includes, but not limited to, incidents in which the facility or facility staff failed to identify hazards, properly assess and evaluate for the risk of an accident; facility failed to eliminate hazards, if possible, and implement interventions to reduce risk, including adequate supervision; and/or monitor for effectiveness of interventions and modify when necessary.	F 609	- The administrator or designee will complete audits of employee understanding of Abuse Prohibition/Vulnerable Adult Plan and of all risk management/incident reports to ensure that all incidents requiring reporting to the state agency were completed. Any discrepancies identified with timely reporting will be resolved. Audits will be conducted (x1) week for 4 weeks, (x1) monthly for 2 months. Audits findings will be brought to QAPI each month to determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. Audits will need to show improvement in areas audited to be discontinued by the QAPI team.	
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	F 677		4/28/21

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F 677	Continued From page 5 by: Based on observation, interview, and document review, the facility failed to ensure timely incontinence cares were provided for 1 of 2 residents (R4) whom were incontinent and dependent upon staff for incontinence care. Findings include: R4's face sheet printed 3/18/21, indicated R4's diagnosis included Alzheimer disease, muscle weakness, and congestive heart failure. R4's quarterly Minimum Data Set (MDS) dated 1/21/21, indicated R4 had a severe cognitive impairment, required extensive - total assistance for most activities of daily living (ADLs), and was always incontinent of bladder and bowel. R4's ADL Care Area Assessment (CAA) dated 5/12/20, indicated R4 required extensive assistance for toileting and personal hygiene. R4's urinary incontinence CAA dated 5/12/20, indicated R4 was at risk for skin breakdown, had urinary incontinence and should be toileted every two - three hours and as needed. R4 had a goal of remaining clean, dry, and free of incontinence related skin breakdown. R4's care plan dated 5/6/20, indicated R4 was at risk for alteration in skin integrity related to functional incontinence and needed turn and reposition every two hours and while lying & while sitting. R4's care plan did not indicate R4 needed to be checked and changed every two hours and as needed. R4's nursing assistant (NA) task sheet provided	F 677	- How corrective action will be accomplished for those residents found to have been affected by the deficient practice. - R4 has been re-assessed for bowel and bladder and the care plan focus goal and interventions for bowel and bladder have been reviewed and revised according to assessment. CNA assignment sheet have been updated to reflect current interventions for check and change according to the assessment and staff is educated to this resident□s plan of care. - How the facility will identify other residents having the potential to be affected by the same deficient practice. - The facility has an ADL policy which remains current. The facility will conduct a full-house audit for all residents for bowel and bladder assessment current and bowel and bladder care plan current with updates to the nursing assistant tasks/assignment sheets. - What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. - The licensed nurse under the direction of nursing management will complete assessments for resident□s bowel and bladder status upon admission, quarterly and annually according the MDS. The care plans will be implemented or revised based on the assessment, to ensure cares providers are in accordance with the plan of care. - All licensed nurses will receive education on assessing and care planning	

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F 677	Continued From page 6 3/17/21, indicated R4 utilized a brief, and directed staff to check and change R4's brief every two hours and as needed. R4 was observed during personal care on 3/18/21, at 6:45 a.m. and was incontinent. R4 was dressed and repositioned in bed by NA-E. R4 was transferred to her Broda chair at 7:30 a.m. and remained in her Broda chair without being checked and changed for incontinence until 11:35 a.m., a total of 4 hours and 50 minutes. When interviewed on 3/18/21, at 11:10 a.m. NA-B verified R4 should be checked every two hours and changed if needed. NA-B stated she thought R4 was changed by NA-C and DON at 8:30 a.m. because she overheard, they were going into R4's room. NA-B stated they typically check and change her "every 3 hours maybe." When interviewed on 3/18/21, at 11:19 a.m. NA-D verified R4 was supposed to be checked and toileted every two hours. NA-D stated she thought NA-B had toileted R4 and stated, "it should have been at 10:30 a.m., I haven't changed her though." At 11:22 a.m. NA-D asked NA-B if she had checked or changed R4. NA-B stated she had not. NA-D and NA-B stated in order to know when residents have or have not received cares, "Basically we just talk to each other." When interviewed on 3/18/21, at 11:30 a.m. licensed practical nurse (LPN)-B verified R4 was supposed to be toileted every two hours and stated, "It's on their care sheets, they should know, they should be checking and changing her every 2 hours." LPN-B stated, "it's hard" and	F 677	bowel and bladder and incontinence care. The licensed nurses will be responsible to ensure the CNA task/assignment sheets include the resident□s current ADL and incontinence care needs. All CNA□s will be educated on providing ADL, incontinence care according to the residents individualized plan of care1 utilizing CNA task/assignment sheets. - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. - Director of Nursing or designee will complete audit for five residents. Current bowel and bladder/incontinence care assessments and care plans and update CNA assignment sheets. In addition, will complete audit for two residents on random shifts to observe that residents are provided with ADL care according to the care plan. Audits will be conducted (x1) week for 4 weeks, (x1) monthly for 2 months. Audits findings will be brought to QAPI each month to determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. Audits will need to show improvement in areas audited to be discontinued by the QAPI team.	

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F 677	Continued From page 7 further stated she was training a new nurse today but normally she was on the floor checking to make sure toileting for R4 and other residents was being completed. At 11:35 a.m. NA-D and NA-B laid R4 down in her bed and changed her brief. R4 had been incontinent of urine and had dried feces on her perineal area. When interviewed on 3/18/21, at 12:00 p.m. RN-C verified R4 should be changed every two hours due to skin impairment. RN-C stated the NA's do not have room assignments and rely on verbal communication about resident cares. When interviewed on 3/18/21, at 3:16 p.m. the DON verified R4 was supposed to be checked and changed every 2 hours and as needed and stated, "there is no reason she wasn't toileted, she should have been." The facilities activities of daily living (ADL) policy dated 2018, indicated appropriate care will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care.	F 677		
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 ulcers unless the individual's clinical condition	F 686		4/28/21

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F 686	Continued From page 8 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 comprehensively assess and implement pressure ulcer (PU) interventions for 2 of 4 resident (R4 and R1) identified whom had current pressure ulcers. Findings include: R4's face sheet printed 3/18/21, indicated R4's diagnosis included Alzheimer's disease, unstageable pressure ulcer of left heel, and muscle weakness. R4's quarterly Minimum Data Set (MDS) dated 1/21/21, indicated R4 had a severe cognitive impairment, used a wheelchair, required extensive assistance for bed mobility and was dependent for transfers. The MDS further indicated R4 had one unstageable pressure ulcer and at risk for pressure ulcers. R4's pressure ulcer and injury Care Area Assessment (CAA) dated 5/12/20, indicated R4 was at increased risk of skin breakdown. The CAA called for toileting and repositioning every two - three hours, skin checks and peri-care with morning and evening caress, and weekly skin audit. R4's had a Braden Scale (scale to determine risk level for PU development) dated, 2/4/20 that	F 686	- How corrective action will be accomplished for those residents found to have been affected by the deficient practice. - R1 has discharged from the facility. - R4 bowel and bladder assessment was re-assessed and revised on 4/14. Revisions have been added/updated in resident□s care plan and age sheets. Licensed nurse or appointee will re-assess patient□s tissue tolerance evaluation, lying and sitting assessments. and offloading. Licensed nurse or appointee will audit and assess wheelchair and bed-time to determine offloading is in place. - How the facility will identify other residents having the potential to be affected by the same deficient practice. - The facility has a policy for Pressure Ulcer/Injury Risk Assessment which is reviewed and remains current. - The facility will audit all current residents for completion of comprehensive assessment and implementation of interventions for all identified residents with pressure ulcers. - What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. - The nursing staff will be educated to	

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F 686	Continued From page 9 indicated no risk for pressure ulcers, and on 2/10/20 the scale was updated and identified R4 was at mild risk and required assistance with turning and repositioning. R4 remained at mild risk and pressure relieving mattress, wheelchair cushion and Broda chair (tilt-in-space positioning chair) was identified as interventions. The Braden Scale on 1/21/21 identified R2 had increased to moderate risk for PU. There were no additional interventions were identified. The Treatment Administration Record (TAR), based on physicians orders, identified on 12/15/20, R4 had left heel skin prep twice a day and float heels in bed, twice a day for wound care. The TAR was updated on 12/29/20, clean wound with wound cleanser and skin prep, and cover with Medipore (a breathable soft cloth) dressing. change as needed, donn (place on) Previlon boots. TAR was updated on 1/13/21, administer oxycodone, 30 minutes before dressing change, and clean with wound cleanser or saline, pat dry and apply skin prep to peri wound skin, medi honey (honey-based gel wound dressing) to wound bed and cover with foam dressing. Change daily and as needed. R4's care plan was last updated 2/22/21, indicated R4 was at risk for alteration in skin integrity and directed staff to turn and reposition every two hours while lying and while sitting and as needed. R4's care plan did not indicate R4 had a current pressure ulcer or include interventions for the pressure ulcers, even though they had developed a PU on 11/14/2020.	F 686	complete a weekly skin inspection for all current residents and new admissions to identify skin issues. - The licensed nurse will be re-educated to complete assessments of pressure ulcers weekly using the pressure wound evaluation form in PCC and develop care plan interventions for the continued treatment of pressure ulcers. Staff will also utilize the wound process checklist and required tasks for identified pressure ulcers to include updating the primary MD with skin changes. - The facility has a wound NP who rounds each Tuesday with the licensed nurse. The facility will implement a wound committee to be held weekly after wound rounds are completed. - All licensed nursing staff will be provided with re-education on assessing and care planning pressure ulcer. All nursing staff including CNA□s will be re-educated with providing skin and pressure ulcer treatment according to physician orders and the residents plan of care. The staff will utilize CNA task/assignment sheet which include current interventions for skin and pressure ulcers. - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. - The Director of Nursing or designee will complete audit for weekly skin inspections for ten residents and corresponding wound evaluation assessments for five residents with pressure ulcers. In addition, the DON or	

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F 686	Continued From page 10 R4's nursing assistant (NA) task sheet provided 3/17/21, indicated R4 had a pressure wound on her left heel, needed a pillow under her calves while in her wheelchair, needed to wear Prevalon booties (boot used to keep pressure off the heel), float her heels (heel positioned so they do not have contact with a surface) and staff turned and reposition R4 every two hours. The Weekly Skin Inspection form, indicates skin evaluation to identify any abnormalities observed, and define site and description along with a comment section. The Weekly Skin Inspection form identified the following: 11/14/20, first identified a "Pressure area to left heel." There was no description or characteristics identified as part of the weekly skin inspection form. 11/22/20, "There was not any skin issue noted." 11/29/20, "Left heel pressure area measuring approx. 2.5 centimeters (cm.)" There was no indication if this area was open or other characteristics of the PU. 12/6/20, was blank with nothing written. 12/13/20, indicated "no new skin issues." 12/20/20, indicated "bruise on arms and hands, delicate skin, bruises featly." There was no mention of the PU. 1/3/21, indicated "pressure ulcer on left heel, treatment is ongoing." 1/10/21, indicated "left heel no drainage, no s/s of infection no redness no foul odor." 1/17/21, indicated "pressure ulcer on left heel, old bruises on arms, legs, skin easily bruises. Open areas on rear lower right leg. 1/24/21, indicated "pressure ulcer measuring	F 686	designee will complete observational audits of two residents weekly that current pressure ulcer interventions are in place. Audits will be conducted (x1) week for 4 weeks, (x1) monthly for 2 months. Audits findings will be brought to QAPI each month to determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. Audits will need to show improvement in areas audited to be discontinued by the QAPI team.	

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approx 1.5 length 1.5 width with scant tan colored drainage no odor, no s/s of infection dressing applied, heel protector in place."
1/31/21, indicated "wound on right heel, treatment ongoing."
2/7/21, indicated "redness noted underneath the right breast"
2/14/21, indicated "dry scaly skin on BLE (bilateral lower extremities), old bruises on arms bilaterally, wound on left heel, treatment ongoing."
2/21/21, indicated "wound to left heel, periwound with no drainage, odor, no redness surrounding wound, to skin, area cleansed with wound cleanser, skin prep to periwound, medi-honey foam dressing. boots maintained for reduction of pressure."
2/28/21, indicated "pressure ulcer on left heel, treatment ongoing. scaly dry skin easily bruises."
3/7/21, indicated "left heel dressing dry and intact."
3/14/21, indicated "skin tear on right thigh healed, pressure ulcer on left heel healing."

The facility Weekly Pressure Wound Evaluation Forms identified the following:
1/6/21, indicated wound length 1.5 cm - width 1.8 cm - no depth indicated. There was no wound stage identified.
2/2/21, indicated length 1.0 cm- width 1.5 cm- depth 0.2 cm. The wound was unstageable.
2/9/21, indicated length 1.5 cm - width 1.5 cm - no depth indicated. The wound was unstageable.
2/16/21, indicated length 1.0 cm - width 1.5 cm - Depth 1.0 cm. The wound was unstageable.
2/23/21, indicated length 1.0 cm- width 2.0 cm- depth 1.5 cm. The wound was unstageable.
3/2/21, indicated length 1.0 cm- width 1.0 cm - depth 0.5 cm- The wound was unstageable.
3/9/21, indicated length 1.0 cm- width 1.0 cm-

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depth 0.5 cm. The wound was unstageable. 3/16/21, indicated length 1.0 cm- width 1.5 cm- depth 1.0 cm. The wound was unstageable with 25% granulation (fibrous connective tissue and blood vessels), 75% slough (dead skin tissue), and scant (minimal) serosanguinous (thin) drainage. and noted to have "increased in size and depth today" and was painful to R4.

There is no indication the facility completed consistent monitoring of R4's PU that included pressure ulcer staging, characteristics of the PU that included skin color, moisture, temperature, integrity, progress toward healing, and if infection or pain were present. These characteristics and monitoring were not identified consistently even though R4's developed their PU on 11/14/2020.

When interviewed on 3/18/21, at 3:16 p.m. the director of nursing DON verified wound evaluations should be done weekly and RN-C should have been documenting R4's weekly wound notes.

In addition:

R4 was observed on 3/18/21, at 6:45 a.m. nursing assistant (NA)-E removed positioning pillows from below R4's feet, changed R4's brief, dressed, and repositioned R4. NA-E did not replace the pillows below R4's feet and R4's heels were resting on the mattress.

On 3/18/21, at 7:30 a.m. DON and NA-C transferred R4 out of bed and into her Broda chair and wheeled R4 into the dining room for breakfast. Staff did not place pillows under R4's calves to float heels per the direction in the NAR task sheet. R4's Lt heel pressure ulcer was

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resting directly on the foot rest of the Broda chair.

On 3/18/21, at 7:47 a.m. R4 was sitting in dining room and had not been repositioned. R4 had no pillows under calves while in her wheelchair.

When interviewed on 3/18/21, at 8:00 a.m. NA-C verified R4 was supposed to have pillows under her feet to float heels. NA-C verified pillows were not there when she and the DON transferred R4 at 7:30 a.m. NA-C stated she was not aware R4 was to have pillows under calves when she was in her wheelchair.

During continuous observation R4 was observed on 3/18/21 from 8:23 a.m. sitting in the dining room, with her Lt heel pressure ulcer that was resting directly on the padding of the Broda chair. She continued to remain in this same positron with her heels touching the chair until 11:35 a.m. when R4 was flayed down in bed, a total of 3 hours and 12 minutes without relieving pressure on her buttock or PU on her heel.

When interviewed on 3/18/21, at 11:10 a.m. NA-B verified R4 had a pressure ulcer on her heel. R4 verified pillows were not in place under R4's calves and that R4 was supposed to be repositioned every two hours.

When interviewed on 3/18/21, at 11:19 a.m. NA-D verified R4 had a pressure ulcer on her heel. R4 verified pillows were not in place under R4's calves and that R4 was supposed to be repositioned every two hours but she "had not done that for her."

When interviewed on 3/18/21, at 11:30 a.m. licensed practical nurse (LPN)-B verified R4 was

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to be repositioned every two hours and stated, "they can reposition her in the Broda chair or lay her down in the bed." LPN-B further stated, "it's hard" and further stated she was training a new nurse today but normally she was on the floor checking to make sure care for R4 and other residents was being completed.

At 11:35 a.m. NA-D and NA-B laid R4 down in her bed and changed her brief. No pillows were placed under R4's feel when laid in bed.

At 11:46 a.m. RN-C examined R4's skin and measured the wound on her left heel. During care, R4 stated her heel hurt and was quite painful at times. RN-C completed wound care and lowered R4's bed. NA-D and NA-B asked RN-C if R4 could get up for lunch. RN-C stated, "no, I think she needs to offload for a while". Even though R4 had a PU on her heel, her heels remained in contact with the bed and were not placed on a pillow to alleviate pressure to her heels.

When interviewed on 3/18/21, at 12:00 p.m. RN-C verified R4 was not able to reposition herself and should be repositioned every two hours. RN-C verified R4 should have her heels floated and stated she would expect a pillow under her calves when she is in her wheelchair and while in bed.

At 12:10 p.m. and 2:49 p.m. R4 was lying in bed and had no pillow in place to float her heel, and her heels were resting directly on the bed.

R1's annual Minimum Data Set (MDS) dated

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3/6/21, indicated R2 had spinal stenosis (narrowing of the spinal column), fusion of the spine, and moderately impaired cognition. R1 was totally dependent upon staff for transfers and required extensive assistance with bed mobility.

R1's pressure ulcer/injury Care Area Assessment (CAA) dated 3/8/21, indicated R1 was at risk for skin breakdown due to incontinence and reduced mobility. The CAA further indicated R1 needed to be repositioned every two to three hours.

R1's care plan dated 3/1/21, indicated R1 was at risk for skin breakdown due to fragile skin. R1's care plan lacked interventions related to repositioning.

R1's Nursing Assistant Task Sheet dated 3/1/21, indicated R1 needed assistance with bed mobility once per shift and as needed.

R1's physical therapy note dated 3/2/21, indicated R1 was dependent on staff for all mobility.

R1's Braden score (skin assessment) dated 3/2/21, was 19-23 which indicated R1 was at no risk for pressure injury and was able to make major and frequent position changes independently, even though R1's MDS indicated on 3/6/21 he was total dependence.

R1's tissue tolerance observation (laying) dated 3/2/21, indicated R1 turned and repositioned himself in bed, at night, although R1 was noted to need extensive assistance with bed mobility in the MDS. R1's tissue tolerance observation (sitting) dated 3/3/21, indicated R1 had dry and intact skin, was not independently mobile, was high risk for pressure injury, and needed to be turned and

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repositioned frequently. R1's tissue tolerance evaluation and skin risk factors dated 3/3/21, indicated R1's Braden score was actually 10-14 which indicated a moderate/high risk for pressure injury and frequently sat. R1 needed be adjusted and moved frequently to avoid a pressure ulcers.

R1's weekly skin assessment dated 3/6/21, indicated R1's skin integrity was noted as clean, dry, and intact and did not indicate any pressure injuries were present.

R1's integrated wound care note dated 3/9/21, indicated a consultation was requested for skin concerns which included a coccyx wound. R1's treatment recommendations included the application of dressings to bony prominence's, application of calmoseptine cream daily and as needed, monitoring pressure/offloading to the elbows and heels, and turning and repositioning was to be conducted, per facility protocol.

R1's Treatment Assessment Record (TAR) dated 3/10/21, did not identify the dressing or application of calmoseptine cream.

R1's face sheet printed 3/18/21, indicated R1 was discharged to the hospital on 3/11/21 at 2:30 p.m.

R1's hospital admission note dated 3/11/21, indicated R1 had presented to the emergency room from the facility with had stage 1 pressure areas to bilateral heels and coccyx present on admission. There was no mention of bilateral heel PU at the nursing home.

R1's hospital note dated 3/11/21, indicated "left buttocks pressure ulcer POA (present on admission)."

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R1's hospital note dated 3/15/21, indicated R1 had a stage 1 pressure ulcer present which the hospital was treating with barrier cream and offloading weight with repositioning.

During an interview on 3/17/21, at 1:32 p.m. family member (FM)-B verified R1 had "some redness" on coccyx upon admission to the facility and was unsure how it was being treated.

During an interview on 3/17/21, at 1:50 p.m. a hospital registered nurse, (RN)-A stated R1 was alert to himself, but did not know he was in the hospital. RN-A stated R1's coccyx and heels were red, however, had intact skin.

During an interview on 3/17/21, at 2:28 p.m. FM-C stated when she visited R1 in the emergency room, his heels appeared "extremely red" and "inflamed."

During an interview on 3/18/21, at 11:00 a.m. licensed practical nurse (LPN)-A initially stated R1 had a repositioning plan, however, subsequently verbalized R1 may not be on a repositioning plan. LPN-A explained R1 shifted around when in bed. LPN-A was unable to recall if R1 had any skin issues.

During an interview on 3/18/21, at 12:15 p.m. NA-A stated she had not noticed any issues with R1's skin. NA-A stated "everyone is on a reposition plan", and believed R1 was as well. NA-A stated R1 liked to be in a recliner most of the day. NA-A stated staff reclined R1, or helped him shift and adjust but did not specify a frequency.

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During an interview on 3/18/21, at 1:06 p.m. registered nurse (RN)-B stated R1 needed to be repositioned every two hours. RN-A verified R1 did not have the strength to reposition independently. RN-B stated R1 could "slide around some", but was unable to independently off-load pressure. RN-B verified she previously checked R1's sacral area (lower back) as R1 sat most of the time. RN-B stated a barrier cream was used with incontinence cares, but did not recall a coccyx dressing. RN-B was unable to recall any skin issues with R1's heels.

During an interview on 3/18/21, at 4:45 p.m. the director of nursing (DON) stated once an assessment was completed, or once something happened that indicated a need for interventions, the care plan should be updated immediately. The DON stated she or the nurse managers were responsible to update care plans. The DON stated the Nursing Assessment Task Sheet was populated from the care plan. The DON stated she did not understand why R1 did not have repositioning interventions in-place as identified through assessments.

The Pressure Ulcer/Injury Risk Assessment dated 2017, directed a resident-centered care plan and interventions must be based on recognized standards of care and the care plan must be modified as the resident condition changes or if current interventions are deemed inadequate.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 8, 2021

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: E0Y111

Dear Administrator:

The above facility was surveyed on March 17, 2021 through March 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00948	A. BUILDING: _____ B. WING _____	C 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LINDEN LLC	105 WEST LINDEN STREET STILLWATER, MN 55082

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/17/21, through 3/18/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	On 3/17/21, through 3/18/21, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5337049C (MN70970). H5337048C (MN64254), unsubstantiated but issued incidental findings based on the allegation, issued: 1980.	2 000	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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	

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2 000	Continued From page 2	2 000	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.	
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees	2 840		4/28/21

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2 840	Continued From page 3 in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely incontinence cares were provided for 1 of 2 residents (R4) whom were incontinent and dependent upon staff for incontinence care. Findings include: R4's face sheet printed 3/18/21, indicated R4's diagnosis included Alzheimer disease, muscle weakness, and congestive heart failure. R4's quarterly Minimum Data Set (MDS) dated 1/21/21, indicated R4 had a severe cognitive impairment, required extensive - total assistance for most activities of daily living (ADLs), and was always incontinent of bladder and bowel. R4's ADL Care Area Assessment (CAA) dated	2 840	CORRECTED	

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2 840	Continued From page 4 5/12/20, indicated R4 required extensive assistance for toileting and personal hygiene. R4's urinary incontinence CAA dated 5/12/20, indicated R4 was at risk for skin breakdown, had urinary incontinence and should be toileted every two - three hours and as needed. R4 had a goal of remaining clean, dry, and free of incontinence related skin breakdown. R4's care plan dated 5/6/20, indicated R4 was at risk for alteration in skin integrity related to functional incontinence and needed turn and reposition every two hours and while lying & while sitting. R4's care plan did not indicate R4 needed to be checked and changed every two hours and as needed. R4's nursing assistant (NA) task sheet provided 3/17/21, indicated R4 utilized a brief, and directed staff to check and change R4's brief every two hours and as needed. R4 was observed during personal care on 3/18/21, at 6:45 a.m. and was incontinent. R4 was dressed and repositioned in bed by NA-E. R4 was transferred to her Broda chair at 7:30 a.m. and remained in her Broda chair without being checked and changed for incontinence until 11:35 a.m., a total of 4 hours and 50 minutes. When interviewed on 3/18/21, at 11:10 a.m. NA-B verified R4 should be checked every two hours and changed if needed. NA-B stated she thought R4 was changed by NA-C and DON at 8:30 a.m. because she overheard, they were going into R4's room. NA-B stated they typically check and change her "every 3 hours maybe." When interviewed on 3/18/21, at 11:19 a.m. NA-D	2 840		

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2 840	Continued From page 5	2 840		

verified R4 was supposed to be checked and toileted every two hours. NA-D stated she thought NA-B had toileted R4 and stated, "it should have been at 10:30 a.m., I haven't changed her though."

At 11:22 a.m. NA-D asked NA-B if she had checked or changed R4. NA-B stated she had not. NA-D and NA-B stated in order to know when residents have or have not received cares, "Basically we just talk to each other."

When interviewed on 3/18/21, at 11:30 a.m. licensed practical nurse (LPN)-B verified R4 was supposed to be toileted every two hours and stated, "It's on their care sheets, they should know, they should be checking and changing her every 2 hours." LPN-B stated, "it's hard" and further stated she was training a new nurse today but normally she was on the floor checking to make sure toileting for R4 and other residents was being completed.

At 11:35 a.m. NA-D and NA-B laid R4 down in her bed and changed her brief. R4 had been incontinent of urine and had dried feces on her perineal area.

When interviewed on 3/18/21, at 12:00 p.m. RN-C verified R4 should be changed every two hours due to skin impairment. RN-C stated the NA's do not have room assignments and rely on verbal communication about resident cares.

When interviewed on 3/18/21, at 3:16 p.m. the DON verified R4 was supposed to be checked and changed every 2 hours and as needed and stated, "there is no reason she wasn't toileted, she should have been."

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2 840	Continued From page 6 The facilities activities of daily living (ADL) policy dated 2018, indicated appropriate care will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure residents are offered toileting as identified through resident assessment. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
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.	2 900		4/28/21

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2 900	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure ulcer (PU) interventions for 2 of 4 resident (R4 and R1) identified whom had current pressure ulcers. Findings include: R4's face sheet printed 3/18/21, indicated R4's diagnosis included Alzheimer's disease, unstageable pressure ulcer of left heel, and muscle weakness. R4's quarterly Minimum Data Set (MDS) dated 1/21/21, indicated R4 had a severe cognitive impairment, used a wheelchair, required extensive assistance for bed mobility and was dependent for transfers. The MDS further indicated R4 had one unstageable pressure ulcer and at risk for pressure ulcers. R4's pressure ulcer and injury Care Area Assessment (CAA) dated 5/12/20, indicated R4 was at increased risk of skin breakdown. The CAA called for toileting and repositioning every two - three hours, skin checks and peri-care with morning and evening caress, and weekly skin audit. R4's had a Braden Scale (scale to determine risk level for PU development) dated, 2/4/20 that indicated no risk for pressure ulcers, and on 2/10/20 the scale was updated and identified R4 was at mild risk and required assistance with turning and repositioning. R4 remained at mild risk and pressure relieving mattress, wheelchair	2 900	CORRECTED	

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2 900	Continued From page 8	2 900		

cushion and Broda chair (tilt-in-space positioning chair) was identified as interventions. The Braden Scale on 1/21/21 identified R2 had increased to moderate risk for PU. There were no additional interventions were identified.

The Treatment Administration Record (TAR), based on physicians orders, identified on 12/15/20, R4 had left heel skin prep twice a day and float heels in bed, twice a day for wound care.

The TAR was updated on 12/29/20, clean wound with wound cleanser and skin prep, and cover with Medipore (a breathable soft cloth) dressing. change as needed, donn (place on) Previlon boots.

TAR was updated on 1/13/21, administer oxycodone, 30 minutes before dressing change, and clean with wound cleanser or saline, pat dry and apply skin prep to peri wound skin, medi honey (honey-based gel wound dressing) to wound bed and cover with foam dressing. Change daily and as needed.

R4's care plan was last updated 2/22/21, indicated R4 was at risk for alteration in skin integrity and directed staff to turn and reposition every two hours while lying and while sitting and as needed. R4's care plan did not indicate R4 had a current pressure ulcer or include interventions for the pressure ulcers, even though they had developed a PU on 11/14/2020.

R4's nursing assistant (NA) task sheet provided 3/17/21, indicated R4 had a pressure wound on her left heel, needed a pillow under her calves while in her wheelchair, needed to wear Prevalon booties (boot used to keep pressure off the heel),

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2 900	Continued From page 9 float her heels (heel positioned so they do not have contact with a surface) and staff turned and reposition R4 every two hours. The Weekly Skin Inspection form, indicates skin evaluation to identify any abnormalities observed, and define site and description along with a comment section. The Weekly Skin Inspection form identified the following: 11/14/20, first identified a "Pressure area to left heel." There was no description or characteristics identified as part of the weekly skin inspection form. 11/22/20, "There was not any skin issue noted." 11/29/20, "Left heel pressure area measuring approx. 2.5 centimeters (cm.)" There was no indication if this area was open or other characteristics of the PU. 12/6/20, was blank with nothing written. 12/13/20, indicated "no new skin issues." 12/20/20, indicated "bruise on arms and hands, delicate skin, bruises featly." There was no mention of the PU. 1/3/21, indicated "pressure ulcer on left heel, treatment is ongoing." 1/10/21, indicated "left heel no drainage, no s/s of infection no redness no foul odor." 1/17/21, indicated "pressure ulcer on left heel, old bruises on arms, legs, skin easily bruises. Open areas on rear lower right leg. 1/24/21, indicated "pressure ulcer measuring approx 1.5 length 1.5 width with scant tan colored drainage no odor, no s/s of infection dressing applied, heel protector in place." 1/31/21, indicated "wound on right heel, treatment ongoing." 2/7/21, indicated "redness noted underneath the right breast"	2 900		

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2 900	Continued From page 10 2/14/21, indicated "dry scaly skin on BLE (bilateral lower extremities), old bruises on arms bilaterally, wound on left heel, treatment ongoing." 2/21/21, indicated "wound to left heel, periwound with no drainage, odor, no redness surrounding wound, to skin, area cleansed with wound cleanser, skin prep to periwound, medi-honey foam dressing. boots maintained for reduction of pressure." 2/28/21, indicated "pressure ulcer on left heel, treatment ongoing. scaly dry skin easily bruises." 3/7/21, indicated "left heel dressing dry and intact." 3/14/21, indicated "skin tear on right thigh healed, pressure ulcer on left heel healing." The facility Weekly Pressure Wound Evaluation Forms identified the following: 1/6/21, indicated wound length 1.5 cm - width 1.8 cm - no depth indicated. There was no wound stage identified. 2/2/21, indicated length 1.0 cm- width 1.5 cm- depth 0.2 cm. The wound was unstageable. 2/9/21, indicated length 1.5 cm - width 1.5 cm - no depth indicated. The wound was unstageable. 2/16/21, indicated length 1.0 cm - width 1.5 cm - Depth 1.0 cm. The wound was unstageable. 2/23/21, indicated length 1.0 cm- width 2.0 cm- depth 1.5 cm. The wound was unstageable. 3/2/21, indicated length 1.0 cm- width 1.0 cm - depth 0.5 cm- The wound was unstageable. 3/9/21, indicated length 1.0 cm- width 1.0 cm- depth 0.5 cm. The wound was unstageable. 3/16/21, indicated length 1.0 cm- width 1.5 cm- depth 1.0 cm. The wound was unstageable with 25% granulation (fibrous connective tissue and blood vessels), 75% slough (dead skin tissue), and scant (minimal) serosanguinous (thin) drainage. and noted to have "increased in size and depth today" and was painful to R4.	2 900		

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2 900	Continued From page 11 There is no indication the facility completed consistent monitoring of R4's PU that included pressure ulcer staging, characteristics of the PU that included skin color, moisture, temperature, integrity, progress toward healing, and if infection or pain were present. These characteristics and monitoring were not identified consistently even though R4's developed their PU on 11/14/2020. When interviewed on 3/18/21, at 3:16 p.m. the director of nursing DON verified wound evaluations should be done weekly and RN-C should have been documenting R4's weekly wound notes. In addition: R4 was observed on 3/18/21, at 6:45 a.m. nursing assistant (NA)-E removed positioning pillows from below R4's feet, changed R4's brief, dressed, and repositioned R4. NA-E did not replace the pillows below R4's feet and R4's heels were resting on the mattress. On 3/18/21, at 7:30 a.m. DON and NA-C transferred R4 out of bed and into her Broda chair and wheeled R4 into the dining room for breakfast. Staff did not place pillows under R4's calves to float heels per the direction in the NAR task sheet. R4's Lt heel pressure ulcer was resting directly on the foot rest of the Broda chair. On 3/18/21, at 7:47 a.m. R4 was sitting in dining room and had not been repositioned. R4 had no pillows under calves while in her wheelchair. When interviewed on 3/18/21, at 8:00 a.m. NA-C verified R4 was supposed to have pillows under her feet to float heels. NA-C verified pillows were	2 900		

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2 900	Continued From page 12	2 900		

not there when she and the DON transferred R4 at 7:30 a.m. NA-C stated she was not aware R4 was to have pillows under calves when she was in her wheelchair.

During continuous observation R4 was observed on 3/18/21 from 8:23 a.m. sitting in the dining room, with her Lt heel pressure ulcer that was resting directly on the padding of the Broda chair. She continued to remain in this same positron with her heels touching the chair until 11:35 a.m. when R4 was flayed down in bed, a total of 3 hours and 12 minutes without relieving pressure on her buttock or PU on her heel.

When interviewed on 3/18/21, at 11:10 a.m. NA-B verified R4 had a pressure ulcer on her heel. R4 verified pillows were not in place under R4's calves and that R4 was supposed to be repositioned every two hours.

When interviewed on 3/18/21, at 11:19 a.m. NA-D verified R4 had a pressure ulcer on her heel. R4 verified pillows were not in place under R4's calves and that R4 was supposed to be repositioned every two hours but she "had not done that for her."

When interviewed on 3/18/21, at 11:30 a.m. licensed practical nurse (LPN)-B verified R4 was to be repositioned every two hours and stated, "they can reposition her in the Broda chair or lay her down in the bed." LPN-B further stated, "it's hard" and further stated she was training a new nurse today but normally she was on the floor checking to make sure care for R4 and other residents was being completed.

At 11:35 a.m. NA-D and NA-B laid R4 down in her bed and changed her brief. No pillows were

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2 900	Continued From page 13 placed under R4's feel when laid in bed. At 11:46 a.m. RN-C examined R4's skin and measured the wound on her left heel. During care, R4 stated her heel hurt and was quite painful at times. RN-C completed wound care and lowered R4's bed. NA-D and NA-B asked RN-C if R4 could get up for lunch. RN-C stated, "no, I think she needs to offload for a while". Even though R4 had a PU on her heel, her heels remained in contact with the bed and were not placed on a pillow to alleviate pressure to her heels. When interviewed on 3/18/21, at 12:00 p.m. RN-C verified R4 was not able to reposition herself and should be repositioned every two hours. RN-C verified R4 should have her heels floated and stated she would expect a pillow under her calves when she is in her wheelchair and while in bed. At 12:10 p.m. and 2:49 p.m. R4 was lying in bed and had no pillow in place to float her heel, and her heels were resting directly on the bed. R1's annual Minimum Data Set (MDS) dated 3/6/21, indicated R2 had spinal stenosis (narrowing of the spinal column), fusion of the spine, and moderately impaired cognition. R1 was totally dependent upon staff for transfers and required extensive assistance with bed mobility. R1's pressure ulcer/injury Care Area Assessment (CAA) dated 3/8/21, indicated R1 was at risk for skin breakdown due to incontinence and reduced mobility. The CAA further indicated R1 needed to be repositioned every two to three hours.	2 900		

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2 900	Continued From page 14 R1's care plan dated 3/1/21, indicated R1 was at risk for skin breakdown due to fragile skin. R1's care plan lacked interventions related to repositioning. R1's Nursing Assistant Task Sheet dated 3/1/21, indicated R1 needed assistance with bed mobility once per shift and as needed. R1's physical therapy note dated 3/2/21, indicated R1 was dependent on staff for all mobility. R1's Braden score (skin assessment) dated 3/2/21, was 19-23 which indicated R1 was at no risk for pressure injury and was able to make major and frequent position changes independently, even though R1's MDS indicated on 3/6/21 he was total dependence. R1's tissue tolerance observation (laying) dated 3/2/21, indicated R1 turned and repositioned himself in bed, at night, although R1 was noted to need extensive assistance with bed mobility in the MDS. R1's tissue tolerance observation (sitting) dated 3/3/21, indicated R1 had dry and intact skin, was not independently mobile, was high risk for pressure injury, and needed to be turned and repositioned frequently. R1's tissue tolerance evaluation and skin risk factors dated 3/3/21, indicated R1's Braden score was actually 10-14 which indicated a moderate/high risk for pressure injury and frequently sat. R1 needed be adjusted and moved frequently to avoid a pressure ulcers. R1's weekly skin assessment dated 3/6/21, indicated R1's skin integrity was noted as clean, dry, and intact and did not indicate any pressure injuries were present. R1's integrated wound care note dated 3/9/21,	2 900		

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2 900	Continued From page 15 indicated a consultation was requested for skin concerns which included a coccyx wound. R1's treatment recommendations included the application of dressings to bony prominence's, application of calmoseptine cream daily and as needed, monitoring pressure/offloading to the elbows and heels, and turning and repositioning was to be conducted, per facility protocol. R1's Treatment Assessment Record (TAR) dated 3/10/21, did not identify the dressing or application of calmoseptine cream. R1's face sheet printed 3/18/21, indicated R1 was discharged to the hospital on 3/11/21 at 2:30 p.m. R1's hospital admission note dated 3/11/21, indicated R1 had presented to the emergency room from the facility with had stage 1 pressure areas to bilateral heels and coccyx present on admission. There was no mention of bilateral heel PU at the nursing home. R1's hospital note dated 3/11/21, indicated "left buttocks pressure ulcer POA (present on admission)." R1's hospital note dated 3/15/21, indicated R1 had a stage 1 pressure ulcer present which the hospital was treating with barrier cream and offloading weight with repositioning. During an interview on 3/17/21, at 1:32 p.m. family member (FM)-B verified R1 had "some redness" on coccyx upon admission to the facility and was unsure how it was being treated. During an interview on 3/17/21, at 1:50 p.m. a hospital registered nurse, (RN)-A stated R1 was alert to himself, but did not know he was in the	2 900		

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2 900	Continued From page 16	2 900		

hospital. RN-A stated R1's coccyx and heels were red, however, had intact skin.

During an interview on 3/17/21, at 2:28 p.m. FM-C stated when she visited R1 in the emergency room, his heels appeared "extremely red" and "inflamed."

During an interview on 3/18/21, at 11:00 a.m. licensed practical nurse (LPN)-A initially stated R1 had a repositioning plan, however, subsequently verbalized R1 may not be on a repositioning plan. LPN-A explained R1 shifted around when in bed. LPN-A was unable to recall if R1 had any skin issues.

During an interview on 3/18/21, at 12:15 p.m. NA-A stated she had not noticed any issues with R1's skin. NA-A stated "everyone is on a reposition plan", and believed R1 was as well. NA-A stated R1 liked to be in a recliner most of the day. NA-A stated staff reclined R1, or helped him shift and adjust but did not specify a frequency.

During an interview on 3/18/21, at 1:06 p.m. registered nurse (RN)-B stated R1 needed to be repositioned every two hours. RN-A verified R1 did not have the strength to reposition independently. RN-B stated R1 could "slide around some", but was unable to independently off-load pressure. RN-B verified she previously checked R1's sacral area (lower back) as R1 sat most of the time. RN-B stated a barrier cream was used with incontinence cares, but did not recall a coccyx dressing. RN-B was unable to recall any skin issues with R1's heels.

During an interview on 3/18/21, at 4:45 p.m. the director of nursing (DON) stated once an

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2 900	Continued From page 17 assessment was completed, or once something happened that indicated a need for interventions, the care plan should be updated immediately. The DON stated she or the nurse managers were responsible to update care plans. The DON stated the Nursing Assessment Task Sheet was populated from the care plan. The DON stated she did not understand why R1 did not have repositioning interventions in-place as identified through assessments. The Pressure Ulcer/Injury Risk Assessment dated 2017, directed a resident-centered care plan and interventions must be based on recognized standards of care and the care plan must be modified as the resident condition changes or if current interventions are deemed inadequate. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary repositioning treatment/services to prevent pressure ulcers from developing/worsening. The director of nursing, or designee, could conduct of care delivery to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult	21980		4/28/21

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has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section

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21980	Continued From page 19 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State agency (SA) were notified within 24 hours of allegations of neglect, for 1 of 3 residents (R2) reviewed for allegations of abuse, neglect and injuries of unknown origin. Findings include: R2's face sheet printed 3/19/21 indicated diagnosis included paralytic syndrome (episodes of muscle weakness or paralysis) and dementia. R2's care plan dated 1/16/19, indicated R2 required a maxi lift and assist of two for transfers. R2's progress note dated 8/8/20, at 6:59 p.m. indicated, "CNA summoned writer to resident's room. Maxi lift tipped over during res transfers. Hoyer tipped over after res was lowered to wheelchair, no injuries observed. Maxi lift did not hit resident. Resident denies pain as result of incident. will continue to monitor." R2's progress note dated 8/10/20, at 3:42 p.m. indicated, Resident had maxi lift tip over during a transfer from bed to wheelchair. Staff and agency aide were working together on the transfer and thought the legs of the lift were left closed while the resident was push/pulled into place over his wheelchair causing it to tip onto the ground with him attached to it. Neither resident nor staff were	21980	CORRECTED	

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injured in the incident. DON, MD, and resident's sister informed of the incident. Staff will be reeducated on use of the maxi lift.

Incident Review and Analysis dated 8/11/20, indicated, Staff misused lift equipment (not opening the legs of the Invacare maxi lift during a transfer) and pulled on resident while suspended in sling causing center of gravity to shift and machine to tip onto the ground. Resident was lowered to wheelchair without injury despite still being connected to the lift as it fell. Staff responsible for correct use of equipment, resident diagnoses did not play a role in incident. Education provided for all nursing department staff. Aides who failed to operate equipment correctly reassessed for competency in use of mechanical lift skill.

R2's Pain Evaluation dated 8/11/20, indicated R2 reported occasional, moderate pain within last 5 days and was given Tylenol 1000 mg (milligrams) each morning which was effective.

When interviewed on 3/18/21, at 8:15 a.m. the director of nursing (DON) verified the incident had occurred and stated, "there was an issue with the legs of the lifts." DON stated they facility had considered reporting the incident but did not as R2 did not sustain an injury. Even though R2 had received tylenol daily for five days after the incident occurred.

When interviewed on 3/18/21, at 12:23 p.m. nursing assistant (NA)-E verified on 8/8/20, while she and NA-G transferred R2, the hoyer lift tipped over onto R2. NA-E stated she believed the incident was caused by "an operator error" and she felt NA-G "didn't really know how to maneuver [R2]" so she explained the use of the

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lift to NA-G during the transfer. NA-E stated NA-G was operating the lift and failed to open the legs of the lift, causing R2's weight to shift and the lift 'tipped over" towards R2, causing him to fall into his wheelchair. NA-E stated she did not think the lift landed on R2 and she did not believe R2 "hit anything hard." NA-E stated NA-G went to get licensed practical nurse (LPN)-C to assess R2 who was not complaining of pain at that time and appeared to be "in shock." NA-E stated the facility "assessed us every so often for lift use before the incident." NA-E verified she received post-incident reeducation on lift use.

When interviewed on 3/18/21, at 1:34 p.m. LPN-C verified the incident had occurred and stated he did not remember any further details other than what he had written in the progress notes.

When interviewed on 3/18/21, at 3:16 p.m. DON asked to verify if the concerns with R2 surrounded the incident not being reported and verified she understood the lack of education and operational error on behalf of staff precipitating the incident.

A facility form titled, Mechanical Lifts, indicated NA-E received education on use of lifts including a demonstration on 12/17/19, and education on Mechanical Lifts/Sit-to Stand lifts including a demonstration on 8/7/20, one day before the event occurred.

There was no indication that NA-G had received any education on lifts prior to the incident occurring.

Facility document titled Mechanical Lifts, dated 8/9/20, indicated NA-E and NA-G were

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21980	Continued From page 22 reeducated on the use of lifts on this date. Facility policy titled Abuse Prohibition/Vulnerable Adult Plan, dated 7/5/19, directed Incidents that must be reported to MDH include: Avoidable Accidents: Means that an accident occurred because the facility failed to includes, but not limited to, incidents in which the facility or facility staff failed to identify hazards, properly assess and evaluate for the risk of an accident; facility failed to eliminate hazards, if possible, and implement interventions to reduce risk, including adequate supervision; and/or monitor for effectiveness of interventions and modify when necessary. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		