Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: July 25, 2024

Dear Administrator:

On September 25, 2024, we notified you a remedy was imposed. On October 9, 2024 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 October 1, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 25, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 25, 2024, 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 October 10, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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October 15, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

Re: Reinspection Results
Event ID: 0HHV12

Dear Administrator:

On October 9, 2024 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 September 06, 2024. At this time these correction orders were found corrected.

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
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 25, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: July 25, 2024

Dear Administrator:

On August 9, 2024, we informed you that we may impose enforcement remedies.

On September 6, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 10, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 10, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 10, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Rush City LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 25, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

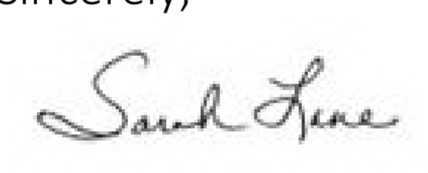
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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,



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
	245348	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 9/4/24 through 9/6/24, 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 complaint was reviewed H53487803C (MN00106270,MN00106447) with a deficiencies cited at F686, F689, F692. 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 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 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		10/1/24

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

Electronically Signed | 10/01/2024

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.

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F 686	Continued From page 1 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 pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in potential harm when 1 of 1 residents (R1)'s wound was not comprehensively monitored or cleaned. Findings include R1's Face Sheet, identified R2 had diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke) and fracture of T7-T8 vertebra. R1's Admission data collection dated 8/23/24, identified R1 arrived at facility on 8/23/24 at 12:00 p.m. R1 required total dependance for transfers from two or more staff. The skin assessment identified R1 had redness to mid upper vertebrae, redness to groin, and left buttock pressure ulcer, and both heels were red. The assessment indicated treatment(s) and monitoring had been set-up. R1's record did not include comprehensive assessments of the areas of impaired skin integrity that included further description, stage of ulcer(s), measurements, and any associated pain. R1's care plan dated 8/24/24, included R1 had alteration in skin integrity related to bruising on bilateral upper extremities, redness in groin and	F 686	F686 Treatment/SVCS to Prevent/Heal Pressure Ulcer Immediate Corrective Action: R1is no longer a resident at the facility. Corrective Action as it applies to others: The Skin Assessment and Wound Management Policy was reviewed and remains current. All residents with wounds were reviewed to ensure there is a current wound assessment within the last week, treatment orders are in place, provider and resident representative aware of the wound and care plan was up to date. All licensed nurses were educated on the Skin Assessment and Wound Management policy with emphasis on the need for wound assessments to be completed weekly and prn if there is a new or deteriorating wound, proper notification to provider and resident representative with new or deteriorating wounds, and the need for treatment orders and care plan to be up to date. Date of Compliance: 10/1/2024 Recurrence will be prevented by:	

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F 686	Continued From page 2 upper mid vertebrae, discoloration of front of right knee, pressure on left buttock. Staff were to monitor skin integrity daily during cares. Weekly skin inspection by nurse. Monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to medical doctor or physician assistant, certified (PA-C). R1's physician orders dated 08/24/24, included the following: -Monitor scattered bruises on bilateral upper extremities for any signs of pain and infection until healed- every shift. -Monitor resident pressure sore on the left bottom for any signs of pain and infection until healed. -Monitor reddened bilateral heals until healed every shift. -Monitor redess to groin until healed. R1's treatment administration record (TAR) identified the aforementioned treatment orders. The documentation indicated the treatments were completed by check marked boxes with no other information aside from the staff intials who completed the documentation. R1's progress note dated 8/24/24 at 12:57 p.m., identified R1's skin was warm/dry, had surgical wound to back and did not have open wounds. Treatment to wound performed on shift as ordered. No further description was given. R1's progress note dated 8/24/24 8:54 p.m. identified Skin was warm/dry. Additionally note indicated No surgical wound noted. Turned and repositioned frequently. Offloading of affected area. Skin treatments performed as ordered. R1's progress note dated 8/24/24 1:56 p.m.,	F 686	Audits of all residents with wounds will be completed weekly x4 then monthly x2 months to ensure they have a current wound assessment, treatment orders in place, provider/resident representative updated, and care plan up to date. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/Designee	

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F 686	Continued From page 3 identified Skin was cool and clammy.Additionally note indicated no surgical wound noted. No open wounds noted. Turned and repositioned frequently. Free from signs and symptoms of pain. R1's progress note dated 8/25/24 at 11:36 p.m. identified Skin is warm/dry. Additionally note indicated no surgical wound noted. No open wounds noted.Turned and repositioned frequently. Offloading of affected area. R1's progress note dated 8/26/24 12:36 p.m., identified Skin is warm/dry. Additionally note indicated No surgical wound noted. No open wounds noted. Turned and repositioned frequently. Offloading of affected area. Free from signs and symptoms of pain. Client Coordination note report from the hospice team dated 08/26/24 identified resident chose not to admit to hospice services. R1 does not ambulate or transfer and is bed bound. Skin was identified to have a coccyx wound. The note did not include a comprehensive assessment of the wound. R1's care plan dated 8/26/24 identified, R1 was on enhanced barrier precautions due to surgical incision, pressure sore on left bottom. Staff were to monitor skin integrity daily during cares Weekly skin inspection by nurse. Report signs symptoms to medical doctor (MD) or physician assistant. R1's progress note dated 8/27/24 4:01p.m. identified Skin is warm/dry. Additionally note indicated no surgical wound noted. No open wounds noted.Turned and repositioned frequently. Offloading of affected area.	F 686		

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F 686	Continued From page 4 R1's Nurse practitioner note dated 8/27/24, identified R1 as a new patient. Skin inspection identified no rashes or ulcers. R1's progress note dated 8/28/24 at 12:28 p.m., Skin is warm/dry. No surgical wound noted. No open wounds noted. Turned and repositioned frequently. Free from signs and symptoms of pain. R1's Hospital note dated 08/29/24 at 2:14 a.m. identified while providing care to R1 writer noted a wound on his left buttocks. See chart for picture. The picture that was included identified a large unstageable oblong pressure ulcer that covered almost all of R1's left buttock. The ulcer base was approximately 95-98% black eschar, with yellowish slough surrounding the top ½ of the eschar, the entire wound periphery was red. Approximately 2-5% of the wound bed was red with one small fluid filled blister located within the wound periphery. The note further indicated R1 was taken to the medical surgical floor and given a shower. Barrier cream applied to his wound on his buttocks. Signed at 2:22 a.m. hospital note at 8:02 a.m. hospital registered nurse (RN)-D reported R1's family friend had called for an update and had reported the facility had informed them the wound was healing well. During a return call interview from 9/6/24 at 2:12 p.m., RN-D reported R1's left buttock wound was identified by the overnight RN from 8/28/29 to 8/29/29. RN-D indicated the facility had not informed the hospital of R1's buttock wound upon or after the transfer to the hospital. RN-D described the wound as a stage three pressure ulcer from the top of R1's buttocks down to the	F 686		

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F 686	Continued From page 5 bottom. The eschar tissue is noted to be black with not a lot of drainage. Yellow crust on the outside on the outer edge. Scar tissue starting to form on the outside of the wound. There may have been a open area on the outer left side. Approximation of size was at least 15 centimeters (CM) by 8.0 or 9.0 cm. During interview on 9/4/24 at 9:03 a.m. family member (FM)-A reported concerns for R1's care while in the facility. FM-A was concerned of the wound located on R1's left buttock and would ask staff how the wound was healing; staff reported the wound was healing and doing really good. Once R1 arrived at the hospital on 8/28/29 hospital staff were concerned regarding the size and coloring of the wound. Hospital staff reported to the family R1's wound was not healing. During interview on 9/6/24 at 3:30 p.m., registered nurse (RN)-B stated he/she completed R1's admission and completed the skin assessment. R1 had a pressure ulcer upon admission on the left buttock that was approximately 5.0 cm by 5.0 cm with some black/purple eschar. RN-B recalled doing the skin assessment and notifying management per the facility's wound care policy. RN-B did not recall if R1 had orders from the hospital for wound cleaning and R1 did not call to clarify orders regarding wounds. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A stated he/she was familiar with R1. On 8/24/24, NA-A recalled R1's bottom to be red but did not remember any ulcers and would consider the skin to be normal otherwise. NA-A stated R1 had ongoing diarrhea and used barrier cream to protect the skin. NA-A stated she would	F 686		

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F 686	Continued From page 6 reposition/offload a couple of times a shift but R1 did not have a specific repositioning/off-loading schedule. During interview on 9/5/24 at 2:30 p.m., nursing assistant (NA)-B stated he/she assisted NA-A with changing R1 on 8/24/24 and did not recall any sores but R1's bottom was red because of diarrhea. They applied a lot of barrier cream During interview on 9/5/24 at 1:54 p.m., registered nurse (RN)-A stated no recollection of R1 having an unstageable wound on his left buttock and only recalled his bottom being red. During interview nurse manager (NM)-A 9/5/24 at 12:38 p.m., nurse manager (NM)-A indicated she participated in wound rounds which were completed weekly. Since R1 was only in the facility for five days so R1 was not seen by the wound nurse on wound rounds. NM-A reviewed R1's record and confirmed the admission record identified a left buttock pressure ulcer and there was not a comprehensive pressure ulcer assessment completed. NM-A indicated it was not possible to ascertain the size of the ulcer upon admission and not possible to identify if the ulcer had deteriorated or improved because there was not a description, or measurements recorded. NM-A indicated pressure ulcers were supposed to be comprehensively assessed upon identification and then weekly. Additionally, wounds should be routinely monitored for changes. During interview on 9/6/24 at 12:58 p.m. nurse practitioner (NP)-A reported R1 had a wound on his buttocks, however never visualized it. Typically, if there was a concern about a wound, a	F 686		

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F 686	Continued From page 7 specialized wound nurse practitioner would do a full skin assessment. NP-A was not notified about any concerns regarding the wound. NP-A reported R1 was in the facility less than a week and R1 may have missed the wound care rounding. NP-A was unable to locate measurements of the left buttock wound upon admission, was not able to locate a monitoring order for R1's wound, there was no documentation of monitoring from 8/24/24 through 8/28/24 and did not locate any treatment orders. The goal for monitoring wounds was to identify if it was getting better or worse. NP-A indicated wounds when identified should be comprehensively assessed to include the stage and measurements to determine if the wound is worsening or improving. During interview on 9/5/24 at 3:20 p.m., director of nursing (DON)-B reviewed R1's record and confirmed the admission skin assessment identified pressure ulcer on R1's left buttock. DON-B stated based on the assessment there should have been treatments orders however, R1's records did not have any treatment orders for the left buttock wound. During interview on 9/6/24 at 1:15 p.m., director of nursing (DON)-A reported she had not ever visualized R1's buttock and had not ever met R. DON-A reported if there were any concerns DON-A would report to NM-A for R1 to be seen for wound rounds. DON-A indicated an unawareness R1 had a pressure ulcer on his left buttock. During interview with administrator on 9/6/24 at 2:05 p.m., administrator reported its the facilities responsibility to prevent or mitigate the risk of	F 686		

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F 686	Continued From page 8 pressure sores and possible wounds. Skin assessment and wound management policy dated 3/2024 identified the purpose is prevention and identification to Provide guidelines for assessing and managing wounds. 1) a pressure ulcer risk assessment (Braden Scale) will be completed per monarchs assessment schedule/grid. 2) implement appropriate preventive skin measures. Examples include, but are not limited to, nutrition interventions, mobility and repositioning plan, pressure redistribution plan. 3) Skin evaluation and skin risk factors form was to be completed prior to the initial MDS, annually and upon significant change. 4) Staff were to provide routine skin inspections (with daily care). 5)Nurses to be notified if skin changes are identified. 6) A weekly skin inspection will be completed by licensed staff. Pressure wounds: New skin problems: when a pressure ulcer is identified, the following actions will be taken: 17. notify provider/treatment orders 18. notify resident representative 19. complete education with resident/resident representative including risk and benefits. 20. Initiate skin and wound evaluation 21. notify nurse manager/wound nurse 22. Referral to dietary 24. review and update care plan including interventions 25. update resident care lists 26. update care plan to identify risk for skin breakdown.	F 686		

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F 686	Continued From page 9 Ongoing skin isses: -update provider and resident/representative as needed. - update care plan as needed.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete comprehensive fall analysis to determine accurate causal factors and implement appropriate care plan interventions to prevent or mitigate the risk of recurrent falls for 1 of 3 residents (R1) reviewed for falls. The facility's failures resulted in actual harm when R1 fell and sustained an acute nondisplaced fracture involving sacral (tailbone). Findings include: R1's Face Sheet, undated, identified R2 had diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke) and fracture of T7-T8 vertebra (thoracic area of back). R1's Admission data collection tool dated 8/23/24, identified R1 arrived at facility on 8/23/24 at 12:00 noon. R1 was not cognitively intact. R1 was	F 689	F689 Free of Accident Hazards/Supervision/Devices Immediate Corrective Action: R1 is no longer a resident at the facility. Corrective Action as it applies to others: The Fall Prevention and Management Policy was reviewed and remains current. All residents at risk for falls were reviewed to ensure a comprehensive fall analysis was completed, causal factors identified, safety interventions in place and care plan is up to date. All licensed nurses were educated on the Fall Prevention and Management Policy with emphasis on the need for a	10/1/24

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F 689	Continued From page 10 assessed for pain with non-verbal sounds (e.g. Crying whining, gasping, moaning or groaning). Vocal complaints of pain (e.g. that hurts, ouch, stop), protective body movements (e.g. bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). R1 was totally dependent on two or more staff for transfers. R1's orders dated 8/23/24 direct R1 to wear back brace (TLSO) during showers, no lifting greater than 10 lbs., wear brace for three months, when head of bed is greater than 30 degrees and this includes when resting in bed, sitting and walking. Avoid excessive, bending, twisting or turning. Monitoring for falls was added on 8/28/24. R1's care plan dated 8/23/24, identified a fall risk related with the intervention for staff to monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes and after remove any potential cause if possible. Educate resident/family/caregivers/ interdisciplinary team as to causes. There was no interventions identified to reduce R1's risk of falls. R1's fall incident report dated 8/23/24 at 8:00 p.m., indicated R1 had an unwitnessed fall. R1 was found face down in between the bed and window with his back brace lying on the bed. R1 was pleasantly confused, orientated to person, and was not able to answer the nurse's questions. R1 moaned in pain when repositioned. Immediate action taken: resident transferred from floor to bed using a full body mechanical lift. Skin check completed no new injury noted, No changes from range of motion from the time of admit. Temperature 100.1 (normal 97-99 degrees	F 689	comprehensive fall analysis, the need to determine accurate causal factors, and implement appropriate care planned interventions to prevent or mitigate the risk for recurrent falls. Date of Compliance: 10/1/2024 Recurrence will be prevented by: Audits of all residents at risk for falls will be completed weekly x4 then monthly x2 months to ensure a comprehensive fall analysis was completed, causal factors identified, safety interventions in place and care plan up to date. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/Designee	

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F 689	Continued From page 11 Fahrenheit), pulse 103 (normal 60-100), respirations 19 (normal 12-18), blood pressure 138/82 (normal 90/60 to 120/80 mmHg), oxygen at 92% (normal 95-100%) on room air. The on call provider was notified and new order to send R1 to the emergency room for further evaluation. Predisposing environmental factors included medical device (bed, wheelchair, cords etc.) Resident removal of safety devices. Predisposing physiological factors include change in behavior, confused, forgetful, unsteady gait, gait imbalance, and impaired memory. Predisposing situation factors include new admission and rolled out of bed. R1's progress note dated 8/24/24, identified R1 returned to the facility after the emergency room (ER) visit at 3:30 a.m. Document titled Incident Review and analysis dated 8/26/24, identified the R1's fall on 8/23/24 at 8:00 p.m. and indicated the interdisciplinary team (IDT) reviewed the fall. The review indicated staff noticed R1 had increased pain, R1 was not incontinent at the time of the incident, there were no cords R1 could have tripped on, and the call light was within reach when R1 was in bed. Contributing factors included: R1 was new admission, was confused, had an unsteady gait, forgetful, unable to realize limitations. The section for current intervention in place directed "see care plan" and the section Possible interventions and Other Interventions was left blank. Although R1's record identified potential causal factors, it was not evident further analysis was completed to identify interventions that addressed R1's contributing risk factors of R1's not recognizing own limitations, confusion, impaired memory, unsteady gait, and forgetful.	F 689		

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F 689	Continued From page 12 R1's care plan dated 8/26/24 identified intervention added on "8/23/24 environmental changes to room: bed position change." During interview on 09/06/24 at 3:30 p.m., registered nurse RN-(B) reported to be the admitting nurse for R1 and aware of R1's fall history prior to admission. RN-B also the nurse who found R1 on the ground on 8/23/24 reported R1 was located face down between the bed and the window, his back brace was on the bed. R1 was incontinent of bowel movement (which was inconsistent with the 8/26/24 Incident Review report). RN-B reported R1's care plan was not followed as R1 did not have TLSO brace on at time of the fall. R1 went to hospital due to unwitnessed fall and pain, arrived back at the facility at 3:30 a.m. with no injuries. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A reported R1 was a "major fall risk" when he was admitted and checked on him frequently because of that. NA-A would use "a lot of pillows "on both sides of him when he was in bed to prevent him from falling. R1 was supposed to have a concave mattress but did not. NA-A recalled on 8/24/24 between 6:00 and 6:45 a.m. she had been walking past R1's room and saw R1 off the edge of the bed with a hand on the ground and foot nearly touching the ground demonstrating the shape of a star fish with his back against the side of the bed. NA-A communicated to RN-A who entered the room, they boosted R1 back to bed. Not long after the "near miss fall" around 7:00 a.m. NA-A went to check on R1 and found him on the floor. R1 was incontinent. NA-A was unsure if R1 hit his head so she had RN-A assess R1 and NA-B assisted	F 689		

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F 689	Continued From page 13 with putting four to five pillows on each side of R1. NA-A thought that was the best course of action to secure R1 in bed. After the fall R1 had been moaning a little during the day. NA-A indicated the intervention to use pillows was not part of the care plan until a few days later. During interview 9/5/24 at 1:54 p.m., RN-A stated he worked on 8/24/24. RN-A stated the first incident was a near fall where he was partially on the floor and then he was found on the floor a short time later. RN-A stated anything he did that day would be documented in the medical record. During interview on 9/5/24 at 2:30 p.m., nursing assistant (NA)-B worked the morning of 8/24/24. NA-B stated R1 had fallen because she assisted NA-A to transfer R1 off the floor and into bed. R1 was incontinent at the time of the fall. During on 9/5/24 at 1:45 p.m., NA-A and DON-A reviewed circumstances of a fall and NA-A confirmed this had happened on her shift of 8/24/24. DON-A reported the facility was unaware of the first incident as RN-A never reported the fall. R1's Mobility Assessment dated 8/26/24 identified, R1 required substantial/maximal assistance for rolling left and right, substantial/maximal assistance for sitting to lying. R1 was dependent to wheel 50 feet with two turns in a manual wheelchair. R1's fall incident report dated 8/28/24 at 9:35 a.m., indicated R1 had an unwitnessed fall in his room at 9:30 am. R1's call light had been on when staff found R1 on the floor lying on his left side near his bed with his back brace on. R1	F 689		

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F 689	Continued From page 14 denied hitting his head and pain. R1's vital signs: blood pressure 103/93, pulse 113, respirations 18, and blood glucose 170 (normal 70-99 mg/dl). No injuries noted at the time of the incident, pain level was zero, and R1 was alert to person however confused. Predisposing physiological fall risk factors included: history of falls, not always able to realize limitations, narcotics, and anticoagulant (blood thinning medication). Predisposing situation factors was blank. The immediate intervention directed staff to use a body pillow while in bed. The physician, administrator, family were notified at "11:23 a.m.-11:28 p.m.". R1's incident report dated 8/28/24 at 10:45 a.m., indicated R1 had an unwitnessed fall at 10:45 a.m. The report indicated R1 had "appeared" to roll out of bed and was found on the floor lying on his back with his back brace on. R1 reported he had not hit his head, denied pain, and no injuries were observed. R1 was confused and his urine appeared to be dark in color compared to baseline. The body pillow was in place and the care plan followed at the time of the fall. Predisposing physiological fall risk factors included: anticoagulant, not always able to realize limitations, and narcotics. The physician, administrator, family were notified at "11:35 a.m.-11:36 p.m.". Immediate action identified was a physician order to send R1 to the hospital for altered mental status and multiple falls. Document titled Incident review and analysis dated 8/28/24, identified the aforementioned fall information with additional information that included the IDT reviewed the incident. Further included the contributing factors was documented as R1 had recent hospice consult, R1 BIMS of 0	F 689		

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F 689	Continued From page 15 (indicating severe cognitive impairment). R1's records did not include a comprehensive analysis for individualized fall interventions that addressed R1's contributing risk factors such as (but not limited to) R1's not recognizing own limitations, confusion, severe cognitive impairment, and narcotic pain medication. R1's care plan was updated on 8/28/24 with the intervention of Body pillow when resident is in bed to prevent falls. R1's hospital record dated 8/28/24, indicated R1 arrived via ambulance at 12:01 p.m. for urgent admission following two unwitnessed falls from his bed today (8/28/24). The note indicated the need for further evaluation because R7 had recent thoracic spine fracture (T7), was on a Plavix therapy (blood thinner), and had a potential head strike. R1 was alert, but unreliable historian, somewhat confused, and had back pain. R1's neurological exam "was listless", low level of interactivity and R1 was only able to answer yes or no questions. CT (computed tomography) identified R1 had an acute nondisplaced fracture involving an anterior marginal endplate osteophytes at S1 with questionable extension into the vertebral body anterior. Further lab tests identified R1 had have worsening leukocytosis (high white blood cells), abnormal urine analysis (UA), COVID 19 positive, evidence of dehydration, and abnormal liver function tests (LFT's). Plan for transfer for further evaluation and treatment following imaging. During interview on 09/04/24 at 9:03 a.m., R1's medical power of attorney (POA) indicated upon admission they made the facility aware R1's fall history and were concerned with the level of	F 689		

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F 689	Continued From page 16 supervision the facility had been providing. POA stated the facility had called them on 8/23/24 at 11:46 to report R1 had a fall out of bed. Then on 8/28/24 at 2:45 p.m. the facility had called to inform them R1 had two falls and was transferred to the hospital. POA stated R1 was hospitalized for an additonal fracture in his spine. During interview on 9/6/24 at 1:37, p.m. nurse manager (NM)-A indicated she had worked on 8/28/24 when R1 rolled out of bed twice. NM-A was not sure if R1 was crawling out of bed or if he had rolled out of bed and why R1 would be trying to get out of bed. NM-A explained she had implemented the intervention of the body pillow after the first fall with the goal of reducing the risk of R1 rolling out of bed, however NM-A did not complete an assessment to determine if the pillow would be effective and/or appropriate. During a subsequent interview on 9/4/24 at 2:27 p.m., Nurse manager NM-A explained after resident falls the nurse immediately completes an assessment for injuries then the nurse completes a checklist. Nurses are expected to document the fall, complete a causal analysis, and determine and immediate intervention to prevent recurrent falls. The IDT then meets to complete the comprehensive analysis and evaluate for any further fall interventions. The expectation was to immediately notify director of nursing (DON), physician, and family. On 9/5/24 at 10:50 a.m., a group interview was held with administrator, NM-A, DON-A, DON-B, regional manager (RM)-A (on phone) and regional director of operations (RD)-A (on phone). DON-A reviewed R1's falls and indicated the fall that occurred on 8/28/24 at 9:35 a.m. staff should	F 689		

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F 689	Continued From page 17 have started neurological assessments. The fall was unwitnessed and was not known if R1 hit his head even though he reported he did not; he was not a reliable historian because he had severe cognitive impairment. R1's level of supervision was not increased to prevent or reduce his risk for falls. R1 was sent to the hospital following the second fall due to being worried about his safety, altered mental status, and signs of infection. First immediate intervention to prevent falls was environmental and moving the bed following the fall on 8/23/24 at 10:00 p.m., Second fall on 8/28/24 at 9:35 a.m. with a second immediate intervention was a body pillow and the third fall on 8/28/24 at 10:45 a.m. R1 was sent to the hospital and did not return. Facility staff were not aware of a 8/24/24 when R1 was found half out of bed, almost on the floor. Facility policy titled fall prevention and management dated 2/2024, identified nursing staff are to complete a fall risk evaluation to identify and document risk factors for falls upon admission, annually, with a significant change in condition, and as needed. Facility staff will identify interventions related to the residents specific risks and try various interventions, based on the nature or type of fall, until falling is reduced, stopped or until the reason for the continuation of falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each residents response to the intervention intended to reduce the risk of falling . When a fall occurs: when a resident has fallen, or is found on the floor, nursing staff will provide comfort, but not move the resident until evaluated for injury. The nursing staff will record vital signs (including orthostatic	F 689		

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F 689	Continued From page 18 BP) when appropriate. If a bump on the head is suspected or confirmed complete neuro checks and update the provider timely. Nursing should utilize the neuro flow sheet per policy. I a resident is noted to be on a blood thinking medication and sustains a fall there is significant risk of bleeding. This should be reported to the provider in a timely manner. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. If a fracture is suspected, do not move resident, but stay with resident and wait for instructions. From medical provider or emergency medical staff to arrive. Reporting to the state survey agency. All falls with serious injury that are determined to be a result of abuse, neglect, exploitation or misappropriation shall be reported to the state survey agency through the only reporting process immediately but not later than 2 hours after identifying the injury. For all other falls, follow the Abuse and Neglect Allegations decision tree. Avoidable accident -means that an accident occurred because the facility failed to evaluate/analyze the hazards and risks and eliminate them, if possible , or if not possible identify and implement measures to reduce the hazards/risks as much as possible and/or implement interventions including adequate supervision and assistive devices, consistent with a residents need, goals, care plan and current professional stands of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident and/or monitor the effectiveness of the intervention and modify the care plan as necessary in accordance with current professional standards	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		10/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	C 09/06/2024

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F 692	Continued From page 19 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess, monitor for signs and symptoms of dehydration and implement timely interventions for 1 of 1 residents (R1) reviewed for hydration status. Findings include: R1's Face Sheet dated 8/23/24, identified R1 had diagnoses that included frontal lobe and executive function deficit following cerebral infarction, aphasia following cerebral infarction, fracture of T7-T8, type 2 diabetes mellitus and benign prostatic hyperplasia without lower urinary tract symptoms.	F 692	F692 Nutrition/Hydration Status Maintenance Immediate Corrective Action: R1 is no longer a resident at the facility. Corrective Action as it applies to others: All at risk residents will be comprehensively reviewed for hydration status. All residents at risk for dehydration will be monitored for signs and symptoms of dehydration and the facility will implement	

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F 692	Continued From page 20 R1's Admission data collection dated 8/23/24, identified R1's nutritional status identified weight loss/gain in the last month and mechanically altered diet. R1 used a foley catheter. R1's care plan dated 8/23/24, identified a focus of nutritional status with the goal to maintain adequate nutritional status. R1 was to have diet regular diet, mechanical soft texture, and nectar consistency. Care plan was updated on 8/26/24 as R1 required assist with feeding. R1's orders dated 8/23/24, identified R1 required staff to obtain output every shift. Staff are to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, nose bleeds. R1's record did not include a comprehensive nutritional assessment that identified daily caloric and fluid needs and goals. R1's fluid intake and output logs were reviewed from 8/23/24 through 8/28/24. R1's record did not include an evaluation of 24-hour daily intake to ensure adequate hydration. R1's Fluid record log included the following documentation: o 8/24/24 at 9:49a.m. 120cc's (cubic centimeters), and at 1:22 p.m. 355cc's o 8/25/24 at 11:39a.m. 120 cc's, at 1:36 p.m. resident refused, at 8:19 p.m. 150 cc's o 8/26/24 at 10:37 a.m. resident refused, at 1:58 p.m. resident refused, at 8:59 p.m. 150 cc's o 8/27/24 at 12:00 noon 480 cc's, at 12:17 p.m. 480cc's, at 7:44 p.m. 240 cc's o 8/28/24 - Resident not available	F 692	timely interventions as needed. The Hydration Policy was reviewed and revised on 9/26/24. All nursing and dietary staff were educated on the Hydration Policy with emphasis on the need to offer fluids at meals, medication passes, at bedside and as needed along with updating the provider and/or dietitian for further monitoring and/or intervention. Date of Compliance: 10/1/2024 Recurrence will be prevented by: Audits of all at risk residents will be completed weekly x4 then monthly x2 months to ensure they have had a comprehensive assessment, and monitoring for dehydration as needed and interventions in place as needed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/Designee	

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F 692	Continued From page 21 R1's output log included the following documentation: o 8/23/24 nocturnal shift (Noc) 650 cc's o 8/24/24 Day 850 cc's, Evening1,000 cc's, Noc 500 cc's o 8/25/24 Day 700 cc's, Evening 350 cc's, Noc 300 cc's o 8/26/24 Day 500 cc's, Evening 250 cc's, Noc 250 cc's o 8/27/24 Day 250 cc's, Evening 350 cc's, Noc 300 cc's o 8/28/24 Hospitalized During interview on 9/6/24 at 10:18 a.m., registered Dietitian-(A) stated typically residents who are short term rehab, without specifically calculating, calculating it would say a rough estimate of 1,500 ml intake a day and food at least 50%. D-A explained based off chart review R1 had poor oral intake and could have benefited from a supplemental source of hydration. He would have been at risk for dehydration because he had Covid and had pressure ulcers. There was a tool to screen for malnutrition however R1 had not been at the facility so one was not completed, and a comprehensive assessment was not completed. The facility had not notified her of any concerns or was a part of his care. R1's record did not include and was not evident R1 was continuously assessed and monitored for signs and symptoms of dehydration for any necessary treatments or interventions even though R1 was at risk for dehydration. R1's progress note dated on 8/23/24 and 8/24/24, indicated R1 was alert and orientated only to himself. R1 had an indwelling urinary catheter	F 692		

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F 692	Continued From page 22	F 692		

(Foley) that was draining clear yellow urine. The note indicated R1 ate meals and drinks fluids by mouth, he had adequate food/fluid intakes this shift. Fluids were encouraged.

R1's progress note dated on 8/25/24 at 1:56 p.m. R1 was disoriented to person place and time. Urine color as clear yellow.

R1's progress note dated on 8/25/24 at 7:55 p.m., identified R1 was alert and oriented to person. 240 cc of fluid this shift, few bites of his meal. R1 was febrile with a temperature of 101.4 (normal ?). Tylenol was administered and effective.

R1's progress note dated on 8/26/24 at 7:55 p.m., indicated R1 was alert and oriented and urine color was clear yellow. Adequate food/fluid intake this shift. Holding food in mouth/cheeks or residual food in mouth after meals. Encouraged fluid intake. R1 was more alert and offered few words but responding to yes/no questions. R1 had 240 cc of fluid for this shift, few bites of meals.

R1's progress note dated on 8/26/24 at 1:18 a.m., identified. R1 had 120 cc nectar apple juice. At 10:17 a.m. no swallowing difficulties observed, encouraged increase fluid intake, and R1 displayed difficulty of movement in extremities.

R1's progress note dated on 8/27/24 at 3:59 p.m. R1 ate 100% breakfast and 50% lunch with fluid intake. Clear amber urine and fluids were encouraged this shift.

R1's history and physical by nurse practitioner dated 08/27/24, Identified since admission R1 was minimally responsive, will occasionally

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F 692	Continued From page 23 answer yes/no questions, R1 had not been out of bed and had poor intake by mouth. R1's progress note dated on at 8/28/24 12:28 p.m., Urine was amber color. Fluids encouraged this shift. Displays a decreased appetite this shift. Decreased fluid intake this shift. R1's progress note dated on 8/28/24 at 11:36 a.m., Order received to send R1 to hospital for altered mental status and multiple falls Resident urine appears to be dark in color compared to baseline. R1's current diet was nectar consistency (resident doesn't like the consistency currently working with speech therapy). R1's Emergency Medical Services (EMS) records identified being notified on 8/28/24, at 10:52 a.m. due to a fall and altered mental status. Facility staff reported to EMS R1 had an altered baseline, but on this day, it was worse and R1 was not using complete sentences like usual. Staff reported R1 was on thickened liquids and not receiving enough water and R1 was dehydrated. Fluid bolus administered and as a result did increase responsiveness. R1 was receiving 550 milliliters (ml) of normal saline. R1's blood pressure at 11:20 a.m. was 98/65 pulse was 113 regular, respirations at 30 with rapid effort. During a follow up return call from 09/06/24 at 1:27 p.m., emergency medical technician (EMT)-A reported to be present and part of the transport assist to the hospital. On arrival R1 was noted to be found sitting alone in a wheelchair in his room with his head down and his fluids were across the room on a table out of his reach. Upon physical observation R1 appeared extremely dehydrated and was difficult to arouse. R1 had thick build up	F 692		

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F 692	Continued From page 24 on his lips, his tongue was dry/discolored, his mouth had a heavy layer of thickened matter on it and EMT-A was concerned R1 was dehydrated. EMT-A had asked the facility staff the last known time R1 had fluids and they were unable to answer. EMT-A explained oxygen and intravenous fluid (IV) fluids were immediately initiated and R1 started to perk up and engage more after he got some fluids. R1's emergency department visit note dated 8/28/24 at 3:18 p.m. indicated R1 arrived to the hospital at 12:01 p.m. R1 was ill appearing and mouth mucous membranes were dry. Abnormal urinalysis and evidence of dehydration. Sodium level was 150 compared to last taken on 8/23/24 when it was 138, creatine now 1.97 compared to 1.05 on 8/23/24. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)- A indicated familiarity with R1. R1 was Covid positive and had to eat in his room, required staff assistance, and did not eat a lot. There were a lot of times when she delivered a food tray to his room and he would be sleeping so she would re-attempt. R1 would maybe eat 25% and drink a cup a day during NA-A'S shift for breakfast and lunch. NA-A recalled R1's urine was usually darker in color and R1 had loose stools and diarrhea frequently. During interview on 9/5/24 at 2:30 p.m., NA-B recalled R1 typically ate about 25% of his food and would help him drink his fluids. He would typically drink about 160 cc's of fluid for breakfast and would drink more than he ate. R1 frequently had diarrhea and his urine was darker in color. During interview on 9/5/24 at 12:26 p.m., NA-C	F 692		

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F 692	Continued From page 25 worked the night shift and R1 was not ever hungry or thirsty. During interview on 9/6/24 at 9:41 a.m., registered nurse (RN)-C stated when residents were on thickened liquids they were at risk for dehydration. When a resident was at risk for dehydration the facility would implement a standing order to monitor for signs and symptoms for dehydration such as confusion, lethargy, tenting of skin or delayed rebound, and dry oral mucosa. The monitoring would be documented on the treatment administration record (TAR). RN-C reviewed R1's record and reported on 8/25/24 an order was put to monitor output however, there was not an order to monitor for dehydration and 24 hour-intake was not calculated. During interview on 9/5/24 at 1:54 p.m., RN-A worked with R1 multiple times. Staff would attempt to assist R1 with eating and drinking but he would not drink a lot. RN-A thought R1 was dehydrated. During interview on 9/5/24 at 12:38 p.m. nurse manager (NM)-A reported residents who were identified at risk of dehydration should see a dietician to lower risks of becoming dehydrated so the nutritionist can assess the fluid needs of the resident. NA-A was not aware if R1 had been seen by the dietician. During interview on 9/5/24 at 2:53 p.m., culinary director (CD)-A recalled R1 required a room tray due to isolation precautions and was on a mechanical soft nectar thick diet (fluids had been altered to a thicker consistency). CD-A recalled R1 was not really eating or drinking. He would be	F 692		

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F 692	Continued From page 26 offered water, juice or milk with all of his meals and would eat and drink about half of what was served. CD-A was involved in general conversations with R1 not drinking enough, but figured R1 was not feeling well because of Covid. CD-A could not recall if R1 was in the facility long enough to meet the dietitian. During interview on 9/6/24 at 12:58 p.m., nurse practitioner (NP)-A reported R1 was at risk of dehydration and was notified by facility staff R1 was not drinking very much fluid. Staff were expected to manage the fluid intake by encouraging fluid consumption and document the results. NP-A would expect ideally a resident in that situation would have had a dietician consult. Policy titled "hydration" dated 09/2012, identified aging is one of the major factors for dehydration resulting from physiological changes in kidney functions, changes in thirst mechanism, ad chronic diseases impairing the elderly's functional abilities. Dehydration in the elderly has long been considered a significant health problem which can lead to increased morbidity and mortality and costly medical care. It is the policy to provide adequate hydration to each resident so that each one is able to achieve and maintain overall health status. The facility will provide adequate hydration by taking into consideration each residents underlying disease state, mental and physical limitations; unless the residents clinical condition indicates that a decline is unavoidable. 1. Upon admission the hospitality services director and/or dietitian will assess each resident for a minimum fluid needs. 2. Hydration status will be assessed upon admission by the nurse manager or other designated nurse and documented on the initial	F 692		

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F 692	Continued From page 27 nursing assessment form. 3. A resident's actual fluid requirement will be jointly determined by the Hospitality service doctor and/or Dietitian and Nurse Manager and/or Director of Nursing, and documented on the Nutrition Assessment Form. 4. Actual fluid requirement will be determined using the following guideline: a. 30cc/kg of actual body weight for resident with a weight within 1WR. b. 100ml/kg for first 10 kg, 50 m/kg for next 10 kg, and 15 ml for remaining kt for underweight and over weight residents. 5. It is believed that a resident shall receive a minimum fluid requirement of 1500 cc/day to compensate for the expected weight loss through skin, lungs, kidneys, and bowel for unusual losses resulting from vomiting, diarrhea, hemorrhage or fever, unless otherwise noted by physician. 6. Additional fluid will be offered when the resident experiences and increased in fluid needs. 7. A resident is receiving approximately 1485 cc fluid from trays at meal times if all fluid is consumed. 8. Additional fluid will be provided between meals though the water pass program. 9. If a therapeutic diet eliminates coffee or limits milk to two cups per day, water or other fluid will be sent on the trays as a replacements. NOTE: for resident with impaired swallowing mechanisms or diabetes mellitus . Water or other appropriate beverages thickened to the appropriate consistency will be used. 10. Fluid intake will be monitored for three days for all newly admitted residents by the primary nurse. If the resident is consuming adequate amounts of fluid, then the fluid intake monitoring	F 692		

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F 692	Continued From page 28 will be discontinued until a risk factor emerges. Note: intake and output (I/O) will be monitored only if ordered by physician. 11. The following are risk factors for dehydration. A resident health may or may not be placed in jeopardy based on the following risk factors: a. Inability to obtain water freely, due to any number of conditions such as a stroke, impaired movement, impaired cognition, impaired communication, or those physically or chemically restrained. b. Extra sweating, such as hot weather, high fever. c. GI volume loss such as vomiting and diarrhea d. Any change in the residents mental status or those residents with persistent cognitive deficits. e. Residents with severe kidney or hepatic failure. f. Residents taking diuretics or any medication that alters volume or electrolyte balance. g. Resident with impaired swallowing. h. Resident with impaired digestion, such as Crohn's disease. i. Resident with significant increase in respiratory rates for prolonged periods of time. j. Residents with wounds that have large volumes of drainage. k. Resident with determined at nutritional risk, l. Resident with meal intake less than 50%. Fluid intake will be monitored for the resident per nurse manager and/or hospitality service directors discretion. If it is determined their condition is compromised due to inadequate fluid intake, their individual fluid requirements will be documented in the care plan	F 692		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

Re: State Nursing Home Licensing Orders
Event ID: 0HHV11

Dear Administrator:

The above facility was surveyed on September 4, 2024 through September 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.

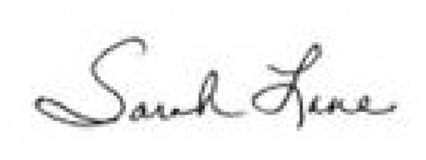
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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	00994	A. BUILDING: _____ B. WING _____	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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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 9/4/24 through 9/6/24, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were reviewed: H53487803C (MN00106270, MN00106447) with a licensing orders issued at 0830, 0900, 0940. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete comprehensive fall analysis to determine accurate causal factors and implement appropriate care plan interventions to prevent or mitigate the risk of recurrent falls for 1 of 3 residents (R1) reviewed for falls. The facility's failures resulted in actual harm when R1 fell and sustained an acute nondisplaced fracture involving sacral (tailbone). Findings include: R1's Face Sheet, undated, identified R2 had	2 830	Corrected	10/1/24

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2 830	Continued From page 3 diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke) and fracture of T7-T8 vertebra (thoracic area of back). R1's Admission data collection tool dated 8/23/24, identified R1 arrived at facility on 8/23/24 at 12:00 noon. R1 was not cognitively intact. R1 was assessed for pain with non-verbal sounds (e.g. Crying whining, gasping, moaning or groaning). Vocal complaints of pain (e.g. that hurts, ouch, stop), protective body movements (e.g. bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). R1 was totally dependent on two or more staff for transfers. R1's orders dated 8/23/24 direct R1 to wear back brace (TLSO) during showers, no lifting greater than 10 lbs., wear brace for three months, when head of bed is greater than 30 degrees and this includes when resting in bed, sitting and walking. Avoid excessive, bending, twisting or turning. Monitoring for falls was added on 8/28/24. R1's care plan dated 8/23/24, identified a fall risk related with the intervention for staff to monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes and after remove any potential cause if possible. Educate resident/family/caregivers/ interdisciplinary team as to causes. There was no interventions identified to reduce R1's risk of falls. R1's fall incident report dated 8/23/24 at 8:00 p.m., indicated R1 had an unwitnessed fall. R1 was found face down in between the bed and window with his back brace lying on the bed. R1 was pleasantly confused, orientated to person,	2 830		

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2 830	Continued From page 4 and was not able to answer the nurse's questions. R1 moaned in pain when repositioned. Immediate action taken: resident transferred from floor to bed using a full body mechanical lift. Skin check completed no new injury noted, No changes from range of motion from the time of admit. Temperature 100.1 (normal 97-99 degrees Fahrenheit), pulse 103 (normal 60-100), respirations 19 (normal 12-18), blood pressure 138/82 (normal 90/60 to 120/80 mmHg), oxygen at 92% (normal 95-100%) on room air. The on call provider was notified and new order to send R1 to the emergency room for further evaluation. Predisposing environmental factors included medical device (bed, wheelchair, cords etc.) Resident removal of safety devices. Predisposing physiological factors include change in behavior, confused, forgetful, unsteady gait, gait imbalance, and impaired memory. Predisposing situation factors include new admission and rolled out of bed. R1's progress note dated 8/24/24, identified R1 returned to the facility after the emergency room (ER) visit at 3:30 a.m. Document titled Incident Review and analysis dated 8/26/24, identified the R1's fall on 8/23/24 at 8:00 p.m. and indicated the interdisciplinary team (IDT) reviewed the fall. The review indicated staff noticed R1 had increased pain, R1 was not incontinent at the time of the incident, there were no cords R1 could have tripped on, and the call light was within reach when R1 was in bed. Contributing factors included: R1 was new admission, was confused, had an unsteady gait, forgetful, unable to realize limitations. The section for current intervention in place directed "see care plan" and the section Possible interventions and Other Interventions was left blank. Although R1's	2 830		

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2 830	Continued From page 5 record identified potential causal factors, it was not evident further analysis was completed to identify interventions that addressed R1's contributing risk factors of R1's not recognizing own limitations, confusion, impaired memory, unsteady gait, and forgetful. R1's care plan dated 8/26/24 identified intervention added on "8/23/24 environmental changes to room: bed position change." During interview on 09/06/24 at 3:30 p.m., registered nurse RN-(B) reported to be the admitting nurse for R1 and aware of R1's fall history prior to admission. RN-B also the nurse who found R1 on the ground on 8/23/24 reported R1 was located face down between the bed and the window, his back brace was on the bed. R1 was incontinent of bowel movement (which was inconsistent with the 8/26/24 Incident Review report). RN-B reported R1's care plan was not followed as R1 did not have TLSO brace on at time of the fall. R1 went to hospital due to unwitnessed fall and pain, arrived back at the facility at 3:30 a.m. with no injuries. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A reported R1 was a "major fall risk" when he was admitted and checked on him frequently because of that. NA-A would use "a lot of pillows "on both sides of him when he was in bed to prevent him from falling. R1 was supposed to have a concave mattress but did not. NA-A recalled on 8/24/24 between 6:00 and 6:45 a.m. she had been walking past R1's room and saw R1 off the edge of the bed with a hand on the ground and foot nearly touching the ground demonstrating the shape of a star fish with his back against the side of the bed. NA-A communicated to RN-A who entered the room,	2 830		

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2 830	Continued From page 6 they boosted R1 back to bed. Not long after the "near miss fall" around 7:00 a.m. NA-A went to check on R1 and found him on the floor. R1 was incontinent. NA-A was unsure if R1 hit his head so she had RN-A assess R1 and NA-B assisted with putting four to five pillows on each side of R1. NA-A thought that was the best course of action to secure R1 in bed. After the fall R1 had been moaning a little during the day. NA-A indicated the intervention to use pillows was not part of the care plan until a few days later. During interview 9/5/24 at 1:54 p.m., RN-A stated he worked on 8/24/24. RN-A stated the first incident was a near fall where he was partially on the floor and then he was found on the floor a short time later. RN-A stated anything he did that day would be documented in the medical record. During interview on 9/5/24 at 2:30 p.m., nursing assistant (NA)-B worked the morning of 8/24/24. NA-B stated R1 had fallen because she assisted NA-A to transfer R1 off the floor and into bed. R1 was incontinent at the time of the fall. During on 9/5/24 at 1:45 p.m., NA-A and DON-A reviewed circumstances of a fall and NA-A confirmed this had happened on her shift of 8/24/24. DON-A reported the facility was unaware of the first incident as RN-A never reported the fall. R1's Mobility Assessment dated 8/26/24 identified, R1 required substantial/maximal assistance for rolling left and right, substantial/maximal assistance for sitting to lying. R1 was dependent to wheel 50 feet with two turns in a manual wheelchair. R1's fall incident report dated 8/28/24 at 9:35	2 830		

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2 830	Continued From page 7 a.m., indicated R1 had an unwitnessed fall in his room at 9:30 am. R1's call light had been on when staff found R1 on the floor lying on his left side near his bed with his back brace on. R1 denied hitting his head and pain. R1's vital signs: blood pressure 103/93, pulse 113, respirations 18, and blood glucose 170 (normal 70-99 mg/dl). No injuries noted at the time of the incident, pain level was zero, and R1 was alert to person however confused. Predisposing physiological fall risk factors included: history of falls, not always able to realize limitations, narcotics, and anticoagulant (blood thinning medication). Predisposing situation factors was blank. The immediate intervention directed staff to use a body pillow while in bed. The physician, administrator, family were notified at "11:23 a.m.-11:28 p.m.". R1's incident report dated 8/28/24 at 10:45 a.m., indicated R1 had an unwitnessed fall at 10:45 a.m. The report indicated R1 had "appeared" to roll out of bed and was found on the floor lying on his back with his back brace on. R1 reported he had not hit his head, denied pain, and no injuries were observed. R1 was confused and his urine appeared to be dark in color compared to baseline. The body pillow was in place and the care plan followed at the time of the fall. Predisposing physiological fall risk factors included: anticoagulant, not always able to realize limitations, and narcotics. The physician, administrator, family were notified at "11:35 a.m.-11:36 p.m.". Immediate action identified was a physician order to send R1 to the hospital for altered mental status and multiple falls. Document titled Incident review and analysis dated 8/28/24, identified the aforementioned fall information with additional information that	2 830		

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2 830	Continued From page 8 included the IDT reviewed the incident. Further included the contributing factors was documented as R1 had recent hospice consult, R1 BIMS of 0 (indicating severe cognitive impairment). R1's records did not include a comprehensive analysis for individualized fall interventions that addressed R1's contributing risk factors such as (but not limited to) R1's not recognizing own limitations, confusion, severe cognitive impairment, and narcotic pain medication. R1's care plan was updated on 8/28/24 with the intervention of Body pillow when resident is in bed to prevent falls. R1's hospital record dated 8/28/24, indicated R1 arrived via ambulance at 12:01 p.m. for urgent admission following two unwitnessed falls from his bed today (8/28/24). The note indicated the need for further evaluation because R7 had recent thoracic spine fracture (T7), was on a Plavix therapy (blood thinner), and had a potential head strike. R1 was alert, but unreliable historian, somewhat confused, and had back pain. R1's neurological exam "was listless", low level of interactivity and R1 was only able to answer yes or no questions. CT (computed tomography) identified R1 had an acute nondisplaced fracture involving an anterior marginal endplate osteophytes at S1 with questionable extension into the vertebral body anterior. Further lab tests identified R1 had have worsening leukocytosis (high white blood cells), abnormal urine analysis (UA), COVID 19 positive, evidence of dehydration, and abnormal liver function tests (LFT's). Plan for transfer for further evaluation and treatment following imaging. During interview on 09/04/24 at 9:03 a.m., R1's medical power of attorney (POA) indicated upon	2 830		

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2 830	Continued From page 9 admission they made the facility aware R1's fall history and were concerned with the level of supervision the facility had been providing. POA stated the facility had called them on 8/23/24 at 11:46 to report R1 had a fall out of bed. Then on 8/28/24 at 2:45 p.m. the facility had called to inform them R1 had two falls and was transferred to the hospital. POA stated R1 was hospitalized for an additonal fracture in his spine. During interview on 9/6/24 at 1:37, p.m. nurse manager (NM)-A indicated she had worked on 8/28/24 when R1 rolled out of bed twice. NM-A was not sure if R1 was crawling out of bed or if he had rolled out of bed and why R1 would be trying to get out of bed. NM-A explained she had implemented the intervention of the body pillow after the first fall with the goal of reducing the risk of R1 rolling out of bed, however NM-A did not complete an assessment to determine if the pillow would be effective and/or appropriate. During a subsequent interview on 9/4/24 at 2:27 p.m., Nurse manager NM-A explained after resident falls the nurse immediately completes an assessment for injuries then the nurse completes a checklist. Nurses are expected to document the fall, complete a causal analysis, and determine and immediate intervention to prevent recurrent falls. The IDT then meets to complete the comprehensive analysis and evaluate for any further fall interventions. The expectation was to immediately notify director of nursing (DON), physician, and family. On 9/5/24 at 10:50 a.m., a group interview was held with administrator, NM-A, DON-A, DON-B, regional manager (RM)-A (on phone) and regional director of operations (RD)-A (on phone). DON-A reviewed R1's falls and indicated the fall	2 830		

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2 830	Continued From page 10 that occurred on 8/28/24 at 9:35 a.m. staff should have started neurological assessments. The fall was unwitnessed and was not known if R1 hit his head even though he reported he did not; he was not a reliable historian because he had severe cognitive impairment. R1's level of supervision was not increased to prevent or reduce his risk for falls. R1 was sent to the hospital following the second fall due to being worried about his safety, altered mental status, and signs of infection. First immediate intervention to prevent falls was environmental and moving the bed following the fall on 8/23/24 at 10:00 p.m., Second fall on 8/28/24 at 9:35 a.m. with a second immediate intervention was a body pillow and the third fall on 8/28/24 at 10:45 a.m. R1 was sent to the hospital and did not return. Facility staff were not aware of a 8/24/24 when R1 was found half out of bed, almost on the floor. Facility policy titled fall prevention and management dated 2/2024, identified nursing staff are to complete a fall risk evaluation to identify and document risk factors for falls upon admission, annually, with a significant change in condition, and as needed. Facility staff will identify interventions related to the residents specific risks and try various interventions, based on the nature or type of fall, until falling is reduced, stopped or until the reason for the continuation of falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each residents response to the intervention intended to reduce the risk of falling . When a fall occurs: when a resident has fallen, or is found on the floor, nursing staff will provide comfort, but not move the resident until evaluated for injury. The nursing staff will record vital signs (including orthostatic	2 830		

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2 830	Continued From page 11 BP) when appropriate. If a bump on the head is suspected or confirmed complete neuro checks and update the provider timely. Nursing should utilize the neuro flow sheet per policy. I a resident is noted to be on a blood thinking medication and sustains a fall there is significant risk of bleeding. This should be reported to the provider in a timely manner. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. If a fracture is suspected, do not move resident, but stay with resident and wait for instructions. From medical provider or emergency medical staff to arrive. Reporting to the state survey agency. All falls with serious injury that are determined to be a result of abuse, neglect, exploitation or misappropriation shall be reported to the state survey agency through the only reporting process immediately but not later than 2 hours after identifying the injury. For all other falls, follow the Abuse and Neglect Allegations decision tree. Avoidable accident -means that an accident occurred because the facility failed to evaluate/analyze the hazards and risks and eliminate them, if possible , or if not possible identify and implement measures to reduce the hazards/risks as much as possible and/or implement interventions including adequate supervision and assistive devices, consistent with a residents need, goals, care plan and current professional stands of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident and/or monitor the effectiveness of the intervention and modify the care plan as necessary in accordance with current professional standards SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise	2 830		

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2 830	Continued From page 12 policies and procedures on resident safety and falls. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are comprehensively assessed and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
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 comprehensively assess pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in potential harm when 1 of	2 900	Corrected	10/1/24

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2 900	Continued From page 13 1 residents (R1)'s wound was not comprehensively monitored or cleaned. Findings include R1's Face Sheet, identified R2 had diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke) and fracture of T7-T8 vertebra. R1's Admission data collection dated 8/23/24, identified R1 arrived at facility on 8/23/24 at 12:00 p.m. R1 required total dependance for transfers from two or more staff. The skin assessment identified R1 had redness to mid upper vertebrae, redness to groin, and left buttock pressure ulcer, and both heels were red. The assessment indicated treatment(s) and monitoring had been set-up. R1's record did not include comprehensive assessments of the areas of impaired skin integrity that included further description, stage of ulcer(s), measurements, and any associated pain. R1's care plan dated 8/24/24, included R1 had alteration in skin integrity related to bruising on bilateral upper extremities, redness in groin and upper mid vertebrae, discoloration of front of right knee, pressure on left buttock. Staff were to monitor skin integrity daily during cares. Weekly skin inspection by nurse. Monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to medical doctor or physician assistant, certified (PA-C). R1's physician orders dated 08/24/24, included the following:	2 900		

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2 900	Continued From page 14 -Monitor scattered bruises on bilateral upper extremities for any signs of pain and infection until healed- every shift. -Monitor resident pressure sore on the left bottom for any signs of pain and infection until healed. -Monitor reddened bilateral heals until healed every shift. -Monitor redess to groin until healed. R1's treatment administration record (TAR) identified the aforementioned treatment orders. The documentation indicated the treatments were completed by check marked boxes with no other information aside from the staff intials who completed the documentation. R1's progress note dated 8/24/24 at 12:57 p.m., identified R1's skin was warm/dry, had surgical wound to back and did not have open wounds. Treatment to wound performed on shift as ordered. No further description was given. R1's progress note dated 8/24/24 8:54 p.m. identified Skin was warm/dry. Additionally note indicated No surgical wound noted. Turned and repositioned frequently. Offloading of affected area. Skin treatments performed as ordered. R1's progress note dated 8/24/24 1:56 p.m., identified Skin was cool and clammy.Additionally note indicated no surgical wound noted. No open wounds noted. Turned and repositioned frequently. Free from signs and symptoms of pain. R1's progress note dated 8/25/24 at 11:36 p.m. identified Skin is warm/dry. Additionally note indicated no surgical wound noted. No open wounds noted.Turned and repositioned frequently. Offloading of affected area.	2 900		

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2 900	Continued From page 15 R1's progress note dated 8/26/24 12:36 p.m., identified Skin is warm/dry. Additionally note indicated No surgical wound noted. No open wounds noted. Turned and repositioned frequently. Offloading of affected area. Free from signs and symptoms of pain. Client Coordination note report from the hospice team dated 08/26/24 identified resident chose not to admit to hospice services. R1 does not ambulate or transfer and is bed bound. Skin was identified to have a coccyx wound. The note did not include a comprehensive assessment of the wound. R1's care plan dated 8/26/24 identified, R1 was on enhanced barrier precautions due to surgical incision, pressure sore on left bottom. Staff were to monitor skin integrity daily during cares Weekly skin inspection by nurse. Report signs symptoms to medical doctor (MD) or physician assistant. R1's progress note dated 8/27/24 4:01p.m. identified Skin is warm/dry. Additionally note indicated no surgical wound noted. No open wounds noted.Turned and repositioned frequently. Offloading of affected area. R1's Nurse practitioner note dated 8/27/24, identified R1 as a new patient. Skin inspection identified no rashes or ulcers. R1's progress note dated 8/28/24 at 12:28 p.m., Skin is warm/dry. No surgical wound noted. No open wounds noted. Turned and repositioned frequently. Free from signs and symptoms of pain. R1's Hospital note dated 08/29/24 at 2:14 a.m.	2 900		

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2 900	Continued From page 16 identified while providing care to R1 writer noted a wound on his left buttocks. See chart for picture. The picture that was included identified a large unstageable oblong pressure ulcer that covered almost all of R1's left buttock. The ulcer base was approximately 95-98% black eschar, with yellowish slough surrounding the top ½ of the eschar, the entire wound periphery was red. Approximately 2-5% of the wound bed was red with one small fluid filled blister located within the wound periphery. The note further indicated R1 was taken to the medical surgical floor and given a shower. Barrier cream applied to his wound on his buttocks. Signed at 2:22 a.m. hospital note at 8:02 a.m. hospital registered nurse (RN)-D reported R1's family friend had called for an update and had reported the facility had informed them the wound was healing well. During a return call interview from 9/6/24 at 2:12 p.m., RN-D reported R1's left buttock wound was identified by the overnight RN from 8/28/29 to 8/29/29. RN-D indicated the facility had not informed the hospital of R1's buttock wound upon or after the transfer to the hospital. RN-D described the wound as a stage three pressure ulcer from the top of R1's buttocks down to the bottom. The eschar tissue is noted to be black with not a lot of drainage. Yellow crust on the outside on the outer edge. Scar tissue starting to form on the outside of the wound. There may have been a open area on the outer left side. Approximation of size was at least 15 centimeters (CM) by 8.0 or 9.0 cm. During interview on 9/4/24 at 9:03 a.m. family member (FM)-A reported concerns for R1's care while in the facility. FM-A was concerned of the wound located on R1's left buttock and would ask staff how the wound was healing; staff reported	2 900		

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2 900	Continued From page 17 the wound was healing and doing really good. Once R1 arrived at the hospital on 8/28/29 hospital staff were concerned regarding the size and coloring of the wound. Hospital staff reported to the family R1's wound was not healing. During interview on 9/6/24 at 3:30 p.m., registered nurse (RN)-B stated he/she completed R1's admission and completed the skin assessment. R1 had a pressure ulcer upon admission on the left buttock that was approximately 5.0 cm by 5.0 cm with some black/purple eschar. RN-B recalled doing the skin assessment and notifying management per the facility's wound care policy. RN-B did not recall if R1 had orders from the hospital for wound cleaning and R1 did not call to clarify orders regarding wounds. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A stated he/she was familiar with R1. On 8/24/24, NA-A recalled R1's bottom to be red but did not remember any ulcers and would consider the skin to be normal otherwise. NA-A stated R1 had ongoing diarrhea and used barrier cream to protect the skin. NA-A stated she would reposition/offload a couple of times a shift but R1 did not have a specific repositioning/off-loading schedule. During interview on 9/5/24 at 2:30 p.m., nursing assistant (NA)-B stated he/she assisted NA-A with changing R1 on 8/24/24 and did not recall any sores but R1's bottom was red because of diarrhea. They applied a lot of barrier cream During interview on 9/5/24 at 1:54 p.m., registered nurse (RN)-A stated no recollection of R1 having an unstageable wound on his left buttock and only recalled his bottom being red.	2 900		

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2 900	Continued From page 18 During interview nurse manager (NM)-A 9/5/24 at 12:38 p.m., nurse manager (NM)-A indicated she participated in wound rounds which were completed weekly. Since R1 was only in the facility for five days so R1 was not seen by the wound nurse on wound rounds. NM-A reviewed R1's record and confirmed the admission record identified a left buttock pressure ulcer and there was not a comprehensive pressure ulcer assessment completed. NM-A indicated it was not possible to ascertain the size of the ulcer upon admission and not possible to identify if the ulcer had deteriorated or improved because there was not a description, or measurements recorded. NM-A indicated pressure ulcers were supposed to be comprehensively assessed upon identification and then weekly. Additionally, wounds should be routinely monitored for changes. During interview on 9/6/24 at 12:58 p.m. nurse practitioner (NP)-A reported R1 had a wound on his buttocks, however never visualized it. Typically, if there was a concern about a wound, a specialized wound nurse practitioner would do a full skin assessment. NP-A was not notified about any concerns regarding the wound. NP-A reported R1 was in the facility less than a week and R1 may have missed the wound care rounding. NP-A was unable to locate measurements of the left buttock wound upon admission, was not able to locate a monitoring order for R1's wound, there was no documentation of monitoring from 8/24/24 through 8/28/24 and did not locate any treatment orders. The goal for monitoring wounds was to identify if it was getting better or worse. NP-A indicated wounds when identified should be comprehensively assessed to include the stage	2 900		

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2 900	Continued From page 19 and measurements to determine if the wound is worsening or improving. During interview on 9/5/24 at 3:20 p.m., director of nursing (DON)-B reviewed R1's record and confirmed the admission skin assessment identified pressure ulcer on R1's left buttock. DON-B stated based on the assessment there should have been treatments orders however, R1's records did not have any treatment orders for the left buttock wound. During interview on 9/6/24 at 1:15 p.m., director of nursing (DON)-A reported she had not ever visualized R1's buttock and had not ever met R. DON-A reported if there were any concerns DON-A would report to NM-A for R1 to be seen for wound rounds. DON-A indicated an unawareness R1 had a pressure ulcer on his left buttock. During interview with administrator on 9/6/24 at 2:05 p.m., administrator reported its the facilities responsibility to prevent or mitigate the risk of pressure sores and possible wounds. Skin assessment and wound management policy dated 3/2024 identified the purpose is prevention and identification to Provide guidelines for assessing and managing wounds. 1) a pressure ulcer risk assessment (Braden Scale) will be completed per monarchs assessment schedule/grid. 2) implement appropriate preventive skin measures. Examples include, but are not limited to, nutrition interventions, mobility and repositioning plan, pressure redistribution plan. 3) Skin evaluation and skin risk factors form was to be completed prior to the initial MDS, annually and upon significant change.	2 900		

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2 900	Continued From page 20 4) Staff were to provide routine skin inspections (with daily care). 5)Nurses to be notified if skin changes are identified. 6) A weekly skin inspection will be completed by licensed staff. Pressure wounds: New skin problems: when a pressure ulcer is identified, the following actions will be taken: 17. notify provider/treatment orders 18. notify resident representative 19. complete education with resident/resident representative including risk and benefits. 20. Initiate skin and wound evaluation 21. notify nurse manager/wound nurse 22. Referral to dietary 24. review and update care plan including interventions 25. update resident care lists 26. update care plan to identify risk for skin breakdown. Ongoing skin isses: -update provider and resident/representative as needed. - update care plan as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate	2 900		

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2 900	Continued From page 21 care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess, monitor for signs and symptoms of dehydration and implement timely interventions for 1 of 1 residents (R1) reviewed for hydration status. Findings include: R1's Face Sheet dated 8/23/24, identified R1 had diagnoses that included frontal lobe and executive function deficit following cerebral infarction, aphasia following cerebral infarction, fracture of T7-T8, type 2 diabetes mellitus and benign prostatic hyperplasia without lower urinary tract symptoms. R1's Admission data collection dated 8/23/24, identified R1's nutritional status identified weight	2 940	Corrected	10/1/24

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2 940	Continued From page 22 loss/gain in the last month and mechanically altered diet. R1 used a foley catheter. R1's care plan dated 8/23/24, identified a focus of nutritional status with the goal to maintain adequate nutritional status. R1 was to have diet regular diet, mechanical soft texture, and nectar consistency. Care plan was updated on 8/26/24 as R1 required assist with feeding. R1's orders dated 8/23/24, identified R1 required staff to obtain output every shift. Staff are to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, nose bleeds. R1's record did not include a comprehensive nutritional assessment that identified daily caloric and fluid needs and goals. R1's fluid intake and output logs were reviewed from 8/23/24 through 8/28/24. R1's record did not include an evaluation of 24-hour daily intake to ensure adequate hydration. R1's Fluid record log included the following documentation: o 8/24/24 at 9:49a.m. 120cc's (cubic centimeters), and at 1:22 p.m. 355cc's o 8/25/24 at 11:39a.m. 120 cc's, at 1:36 p.m. resident refused, at 8:19 p.m. 150 cc's o 8/26/24 at 10:37 a.m. resident refused, at 1:58 p.m. resident refused, at 8:59 p.m. 150 cc's o 8/27/24 at 12:00 noon 480 cc's, at 12:17 p.m. 480cc's, at 7:44 p.m. 240 cc's o 8/28/24 - Resident not available R1's output log included the following documentation:	2 940		

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2 940	Continued From page 23 o 8/23/24 nocturnal shift (Noc) 650 cc's o 8/24/24 Day 850 cc's, Evening1,000 cc's, Noc 500 cc's o 8/25/24 Day 700 cc's, Evening 350 cc's, Noc 300 cc's o 8/26/24 Day 500 cc's, Evening 250 cc's, Noc 250 cc's o 8/27/24 Day 250 cc's, Evening 350 cc's, Noc 300 cc's o 8/28/24 Hospitalized During interview on 9/6/24 at 10:18 a.m., registered Dietitian-(A) stated typically residents who are short term rehab, without specifically calculating, calculating it would say a rough estimate of 1,500 ml intake a day and food at least 50%. D-A explained based off chart review R1 had poor oral intake and could have benefited from a supplemental source of hydration. He would have been at risk for dehydration because he had Covid and had pressure ulcers. There was a tool to screen for malnutrition however R1 had not been at the facility so one was not completed, and a comprehensive assessment was not completed. The facility had not notified her of any concerns or was a part of his care. R1's record did not include and was not evident R1 was continuously assessed and monitored for signs and symptoms of dehydration for any necessary treatments or interventions even though R1 was at risk for dehydration. R1's progress note dated on 8/23/24 and 8/24/24, indicated R1 was alert and orientated only to himself. R1 had an indwelling urinary catheter (Foley) that was draining clear yellow urine. The note indicated R1 ate meals and drinks fluids by mouth, he had adequate food/fluid intakes this shift. Fluids were encouraged.	2 940		

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2 940	Continued From page 24 R1's progress note dated on 8/25/24 at 1:56 p.m. R1 was disoriented to person place and time. Urine color as clear yellow. R1's progress note dated on 8/25/24 at 7:55 p.m., identified R1 was alert and oriented to person. 240 cc of fluid this shift, few bites of his meal. R1 was febrile with a temperature of 101.4. Tylenol was administered and effective. R1's progress note dated on 8/26/24 at 7:55 p.m., indicated R1 was alert and oriented and urine color was clear yellow. Adequate food/fluid intake this shift. Holding food in mouth/cheeks or residual food in mouth after meals. Encouraged fluid intake. R1 was more alert and offered few words but responding to yes/no questions. R1 had 240 cc of fluid for this shift, few bites of meals. R1's progress note dated on 8/26/24 at 1:18 a.m., identified. R1 had 120 cc nectar apple juice. At 10:17 a.m. no swallowing difficulties observed, encouraged increase fluid intake, and R1 displayed difficulty of movement in extremities. R1's progress note dated on 8/27/24 at 3:59 p.m. R1 ate 100% breakfast and 50% lunch with fluid intake. Clear amber urine and fluids were encouraged this shift. R1's history and physical by nurse practitioner dated 08/27/24, identified since admission R1 was minimally responsive, will occasionally answer yes/no questions, R1 had not been out of bed and had poor intake by mouth. R1's progress note dated on at 8/28/24 12:28 p.m., Urine was amber color. Fluids encouraged	2 940		

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2 940	Continued From page 25 this shift. Displays a decreased appetite this shift. Decreased fluid intake this shift. R1's progress note dated on 8/28/24 at 11:36 a.m., Order received to send R1 to hospital for altered mental status and multiple falls Resident urine appears to be dark in color compared to baseline. R1's current diet was nectar consistency (resident doesn't like the consistency currently working with speech therapy). R1's Emergency Medical Services (EMS) records identified being notified on 8/28/24, at 10:52 a.m. due to a fall and altered mental status. Facility staff reported to EMS R1 had an altered baseline, but on this day, it was worse and R1 was not using complete sentences like usual. Staff reported R1 was on thickened liquids and not receiving enough water and R1 was dehydrated. Fluid bolus administered and as a result did increase responsiveness. R1 was receiving 550 milliliters (ml) of normal saline. R1's blood pressure at 11:20 a.m. was 98/65 pulse was 113 regular, respirations at 30 with rapid effort. During a follow up return call from 09/06/24 at 1:27 p.m., emergency medical technician (EMT)-A reported to be present and part of the transport assist to the hospital. On arrival R1 was noted to be found sitting alone in a wheelchair in his room with his head down and his fluids were across the room on a table out of his reach. Upon physical observation R1 appeared extremely dehydrated and was difficult to arouse. R1 had thick build up on his lips, his tongue was dry/discolored, his mouth had a heavy layer of thickened matter on it and EMT-A was concerned R1 was dehydrated. EMT-A had asked the facility staff the last known time R1 had fluids and they were unable to answer. EMT-A explained oxygen and	2 940		

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	00994	A. BUILDING: _____ B. WING _____	09/06/2024

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2 940	Continued From page 26 intravenous fluid (IV) fluids were immediately initiated and R1 started to perk up and engage more after he got some fluids. R1's emergency department visit note dated 8/28/24 at 3:18 p.m. indicated R1 arrived to the hospital at 12:01 p.m. R1 was ill appearing and mouth mucous membranes were dry. Abnormal urinalysis and evidence of dehydration. Sodium level was 150 compared to last taken on 8/23/24 when it was 138, creatine now 1.97 compared to 1.05 on 8/23/24. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A indicated familiarity with R1. R1 was Covid positive and had to eat in his room, required staff assistance, and did not eat a lot. There were a lot of times when she delivered a food tray to his room and he would be sleeping so she would re-attempt. R1 would maybe eat 25% and drink a cup a day during NA-A'S shift for breakfast and lunch. NA-A recalled R1's urine was usually darker in color and R1 had loose stools and diarrhea frequently. During interview on 9/5/24 at 2:30 p.m., NA-B recalled R1 typically ate about 25% of his food and would help him drink his fluids. He would typically drink about 160 cc's of fluid for breakfast and would drink more than he ate. R1 frequently had diarrhea and his urine was darker in color. During interview on 9/5/24 at 12:26 p.m., NA-C worked the night shift and R1 was not ever hungry or thirsty. During interview on 9/6/24 at 9:41 a.m., registered nurse (RN)-C stated when residents were on thickened liquids they were at risk for dehydration. When a resident was at risk for	2 940		

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2 940	Continued From page 27 dehydration the facility would implement a standing order to monitor for signs and symptoms for dehydration such as confusion, lethargy, tenting of skin or delayed rebound, and dry oral mucosa. The monitoring would be documented on the treatment administration record (TAR). RN-C reviewed R1's record and reported on 8/25/24 an order was put to monitor output however, there was not an order to monitor for dehydration and 24 hour-intake was not calculated. During interview on 9/5/24 at 1:54 p.m., RN-A worked with R1 multiple times. Staff would attempt to assist R1 with eating and drinking but he would not drink a lot. RN-A thought R1 was dehydrated. During interview on 9/5/24 at 12:38 p.m. nurse manager (NM)-A reported residents who were identified at risk of dehydration should see a dietician to lower risks of becoming dehydrated so the nutritionist can assess the fluid needs of the resident. NA-A was not aware if R1 had been seen by the dietician. During interview on 9/5/24 at 2:53 p.m., culinary director (CD)-A recalled R1 required a room tray due to isolation precautions and was on a mechanical soft nectar thick diet (fluids had been altered to a thicker consistency). CD-A recalled R1 was not really eating or drinking. He would be offered water, juice or milk with all of his meals and would eat and drink about half of what was served. CD-A was involved in general conversations with R1 not drinking enough, but figured R1 was not feeling well because of Covid. CD-A could not recall if R1 was in the facility long enough to meet the dietitian.	2 940		

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2 940	Continued From page 28 During interview on 9/6/24 at 12:58 p.m., nurse practitioner (NP)-A reported R1 was at risk of dehydration and was notified by facility staff R1 was not drinking very much fluid. Staff were expected to manage the fluid intake by encouraging fluid consumption and document the results. NP-A would expect ideally a resident in that situation would have had a dietician consult. Policy titled "hydration" dated 09/2012, identified aging is one of the major factors for dehydration resulting from physiological changes in kidney functions, changes in thirst mechanism, ad chronic diseases impairing the elderly's functional abilities. Dehydration in the elderly has long been considered a significant health problem which can lead to increased morbidity and mortality and costly medical care. It is the policy to provide adequate hydration to each resident so that each one is able to achieve and maintain overall health status. The facility will provide adequate hydration by taking into consideration each residents underlying disease state, mental and physical limitations; unless the residents clinical condition indicates that a decline is unavoidable. 1. Upon admission the hospitality services director and/or dietitian will assess each resident for a minimum fluid needs. 2. Hydration status will be assessed upon admission by the nurse manager or other designated nurse and documented on the initial nursing assessment form. 3. A resident's actual fluid requirement will be jointly determined by the Hospitality service doctor and/or Dietitian and Nurse Manager and/or Director of Nursing, and documented on the Nutrition Assessment Form. 4. Actual fluid requirement will be determined using the following guideline: a. 30cc/kg of actual body weight for resident	2 940		

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2 940	Continued From page 29 with a weight within 1WR. b. 100ml/kg for first 10 kg, 50 m/kg for next 10 kg, and 15 ml for remaining kt for underweight and over weight residents. 5. It is believed that a resident shall receive a minimum fluid requirement of 1500 cc/day to compensate for the expected weight loss through skin, lungs, kidneys, and bowel for unusual losses resulting from vomiting, diarrhea, hemorrhage or fever, unless otherwise noted by physician. 6. Additional fluid will be offered when the resident experiences and increased in fluid needs. 7. A resident is receiving approximately 1485 cc fluid from trays at meal times if all fluid is consumed. 8. Additional fluid will be provided between meals though the water pass program. 9. If a therapeutic diet eliminates coffee or limits milk to two cups per day, water or other fluid will be sent on the trays as a replacements. NOTE: for resident with impaired swallowing mechanisms or diabetes mellitus . Water or other appropriate beverages thickened to the appropriate consistency will be used. 10. Fluid intake will be monitored for three days for all newly admitted residents by the primary nurse. If the resident is consuming adequate amounts of fluid, then the fluid intake monitoring will be discontinued until a risk factor emerges. Note: intake and output (I/O) will be monitored only if ordered by physician. 11. The following are risk factors for dehydration. A resident health may or may not be placed in jeopardy based on the following risk factors: a. Inability to obtain water freely, due to any number of conditions such as a stroke, impaired movement, impaired cognition, impaired communication, or those physically or chemically	2 940		

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2 940	Continued From page 30 restrained. b. Extra sweating, such as hot weather, high fever. c. GI volume loss such as vomiting and diarrhea d. Any change in the residents mental status or those residents with persistent cognitive deficits. e. Residents with severe kidney or hepatic failure. f. Residents taking diuretics or any medication that alters volume or electrolyte balance. g. Resident with impaired swallowing. h. Resident with impaired digestion, such as Crohn's disease. i. Resident with significant increase in respiratory rates for prolonged periods of time. j. Residents with wounds that have large volumes of drainage. k. Resident with determined at nutritional risk, l. Resident with meal intake less than 50%. Fluid intake will be monitored for the resident per nurse manager and/or hospitality service directors discretion. If it is determined their condition is compromised due to inadequate fluid intake, their individual fluid requirements will be documented in the care plan SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on hydration. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff are aware of resident needs for hydration status and report these findings to their QAPI committee.	2 940		

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2 940	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 940		