Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 27, 2023

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: September 12, 2023

Dear Administrator:

On October 19, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

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

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September 27, 2023

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: September 12, 2023

Dear Administrator:

On September 12, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 12, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 12, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Please contact me with any questions regarding this letter.

Sincerely,

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

DEPARTMENT OF HEALTH

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September 27, 2023

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: Event ID: DCSF11

Dear Administrator:

The above facility survey was completed on September 12, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE GRAND MEADOW, MN 55936

(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 9/11/23 to 9/12/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53675149C (MN96474) with a deficiency issued at F684 H53675247C (MN96680) H53675424C (MN85838) 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/6/23

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

Electronically Signed | 10/06/2023

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

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F 684	Continued From page 1 by: Based on interview and document review the facility failed to initiate care planned interventions for the refusal of care and provide ongoing assessment and monitoring for 1 of 3 residents (R1) reviewed for change in condition. Findings include: R1's admission Minimum Data Set (MDS) dated 8/2/23, identified R1 had moderate cognitive impairment and diagnoses of congestive heart failure (CHF), hypertension, chronic obstructive pulmonary disease (COPD), diabetes mellitus, hyperlimidimia (high cholesterol), asthma, respiratory failure and dependence of supplemental oxygen. R1's cognitive loss/dementia Care Area Assessment (CAA) dated 8/2/23, identified R1 displayed negative mood effects along with behaviors such as hitting and refusal of cares with an analysis of findings listed as potential related to cognition (confusion, mood state and behavioral symptoms). R1's hospital discharge orders dated 8/20/23, identified an order for continuous oxygen at 4 Liters (L). R1's nurse practitioner (NP) follow up visit dated 8/23/23, included further detail related to emergency room stay and included the following: -finding related to pulmonary edema, follow up expected with oncology; -acute worsening of renal function; -markedly diminished DLCO (lung diffusion test) of 32% consistent with advanced emphysema, continue oxygen supplement 4 L nasal cannula to	F 684	POC 9.29.23 F 684 PLAN OF CORRECTION Meadow Manor denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 684, Quality of Care, Grand Meadow Senior Living corrected the deficiency by educating RN-A and DON on ensuring change of condition monitoring is charted in the medical record and resident care plans are being followed by the Regional Clinical Nurse Specialist on 10/03/2023.	

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F 684	Continued From page 2 keep oxygen levels 88%-92%, continue Brea Ellipta (inhaler), Duo Nebs (Nebulizer Treatment) and PRN Albuterol; - R1 did not demonstrate the capacity to acquire, retain, and process relevant facts regarding his medical situation. - R1's mental status was noted to be confused, judgement was noted to be inappropriate. - R1 was having worsening renal function, increased oxygen needs, and increased pulmonary nodules size. R1 had some understanding but is significantly limited in understanding his condition and did not understand treatment options. R1 did not understand potential risk and benefits of treatment options but NP noted she was able to speak to family during the appointment and share seriousness of health condition, comorbidities, recent CT findings. Initially the report indicated R1 agreed he should consider hospice but then became very agitated. R1's care plan dated 7/23/23, identified a goal of taking medication daily with interventions listed as: - Administered oxygen as ordered by medical practitioner prn (as needed). - Avoid taking blood pressure readings after taxing physical activity or emotional distress. - Give cardiac medications as ordered. Observe for side effects such as orthostatic hypotension and increased heart rate and effectiveness. - Observe/document/report to medical practitioner PRN any signs/symptoms of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing, pulse rate lower than programmed rate, lower than baseline blood pressure. - Observe/document/report to medical practitioner	F 684	2. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on ensuring change of condition monitoring is charted in the medical record and resident care plans are being followed by the DON on 09/29/2023. The Director of Nursing and/or designee will audit 2 resident care plans for staff compliance weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit 24 hr report in PCC and in nurses station for change of condition monitoring 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 4 weeks, and then randomly to ensure continued compliance. 3. As part of Grand Meadow Senior Living s ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community s QA Process.	

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F 684	Continued From page 3 PRN any s/sx of CHF: dependent edema of legs and feet, periorbital edema, SOB (short of breath) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain related to intake, crackles and wheezes upon auscultation of the lungs, orthopnea (shortness of breath while lying flat), weakness and/or fatigue, increased heart rate lethargy and disorientation. R1's care plan dated 7/23/23, identified focus of altered respiratory status/difficulty breathing with occasions of shortness of breath related to diagnosis of CHF, COPD, respiratory failure has altered respiratory status/difficulty breathing , shortness of breath with goal of will remain free from complications of CHF & COPD. Interventions listed as: -Administer medications/inhalers/nebulizer treatments as ordered. Observe for effectiveness and side effects -BIPAP/CPAP as ordered. -Observe/document and report to nurse/medical practitioner any changes in orientation, increased restlessness, anxiety and air hunger. - Observe/document and report to nurse/medical practitioner any s/sx of respiratory distress; increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis, cough, pleuritic pain, accessory muscle use, skin color changes to blue/gray. - Provide oxygen as ordered. Provide extension tubing or portable oxygen apparatus to promote independence. Observe pulse oximeter and record. Report abnormalities to medical practitioner. R1's care plan dated 7/23/23 identified focus of care refusal, refuses medications with a goal of	F 684		

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F 684	Continued From page 4 behaviors will not interfere with daily activities and will not cause harm to self or others. Interventions listed as: -Attempt non-pharmacological interventions such as 1:1's, snacks, communication with son and observe effectiveness. - Report to nurse signs and symptoms of the following: confusion, mood change, change in normal behavior, hallucinations/delusions, social isolation, suicidal ideations, withdrawal, decline in ability to help with/do activities of daily living, continence, cognitive function, constipation, fecal impaction, no voiding, shuffle gait, rigid muscles, difficulty with ambulation, balance problems, accidents, dizziness/vertigo, falls, movement problems, tremors, diarrhea, fatigue, insomnia, appetite loss, weight loss and muscle cramps. R1's Behavioral Notes from 8/16/23 to 8/25/23 identified the following: 8/16/23, No behaviors notes, slept 6-8 hours 8/17/23, No behaviors notes, slept 6-8 hours 8/18/23, No behaviors notes, slept 6-8 hours 8/19/13, 8/20/23, 8/21/23, R1's record lacked evidence of documented notes 8/22/23, No behaviors notes, slept 6-8 hours 8/23/23, No behaviors notes, slept 6-8 hours 8/24/23, No behaviors noted, slept 6-8 hours 8/25/23, resident noted yelling out and refusing to wear oxygen. Non-pharmalogical interventions implemented were 1:1 staff time and reorientation. Effectiveness was identified to not be effective. R1 was confused and unable to reorient effectively. R1's behavioral notes lacked evidence care planned interventions were implemented in an attempt to assist R1 to comply with order for continous oxygen of 4 L. No evidence was	F 684		

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F 684	Continued From page 5 identfied R1's son contacted upon R1's refusal to wear oxygen depite this putting R1 in self harm. R1's last recorded vitals were on 8/24/23 at 9:44 a.m., recorded as blood pressure 155/87 (sitting), pulse 71. R1's oxygen saturation levels were identified as the following: 8/23/23 4:04 a.m., 91 % (oxygen via nasal cannula) 8/23/23 7:37 a.m., 93 % (oxygen via nasal cannula) 8/23/23 2:24 p.m., 91 % (oxygen via nasal cannula) 8/24/23 4:06 a.m., 92 % (oxygen via nasal cannula) 8/24/23 10:38 p.m., 93 % (oxygen via nasal cannula) 8/25/23 12:56 a.m., 88 % (oxygen via nasal cannula 90.0 exceeded cannula) R1's medical record lacked evidence of pulse oximeter readings or ongoing monitoring of vitals despite R1's confusion and inability to be reoriented on 8/25/23.. R1's progress notes from 8/19/23 through 8/25/23, included the following: -8/19/23 at 12:05 p.m., Resident checked at 9:51 a.m., SpO2 (oxygen saturation reading) at that time was 81%, as he was talking to the nurse it dropped to 79%. Resident stated he was having difficulties breathing, he was encouraged to breath through his nose and given Albuterol inhaler. Air conditioning was also adjusted as room was warm. Oxygen was set at 5 L, SpO2 increased to 81%. Oxygen decreased to four to 4 L, lungs clear but diminished, discussed condition	F 684		

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F 684	Continued From page 6 with director of nursing (DON). Spoke with resident that we would be putting a call into the doctor and they may want him sent in to be seen due his low oxygen levels. Resident stated, "I don't want to go, they aren't going to do anything anyway, they didn't do anything the last time I went in." Confirmed with resident that he was refusing to go to the hospital if that is what the doctor suggested. He stated, "I'm not going." Oxygen levels were checked again and at 11:30 a.m. 80%SpO2, he continued to complain of a stuffy nose. He was offered sodium chloride nasal solution, while he was sitting on the edge of the bed. He then blew his nose. Checked oxygen after 10 minutes and was up to 88% while sitting on the edge of the bed. Will continue to monitor, and notified director of nursing DON of changes. -8/19/23 at 12:52 p.m., Call placed to on call physician, described resident's condition. The physician suggested R1 should be sent to emergency department as R1 most likely needed to be diuresed (procedure to assist patient to get rid of excess fluid because of a health condition) and did not feel comfortable doing so in the nursing home because of his poor kidney function and heart condition. A call was placed to R1's son, was unable to reach him, left a message for him to call the facility. The son returned the call, talked to son and explained situation and requested to send patient, and just identifed where not to send them. -8/19/23 3:25 p.m., spoke with resident and explained that he should go to ED and get the treatment suggested by the doctor and he stated "ok," also told him that they had spoken with R1's son and he also agreed it was a good idea. Son was aware, will call once ambulance arrives to	F 684		

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F 684	Continued From page 7 take resident. - 8/20/23 2:24 a.m., The facility notified resident will be sent back. ED stated that the CT of the lungs and chest revealed some nodules in the lungs of the resident which required follow up visits with gastrointestinal and oncology. The nodules consequently are causing "fluid back up" in the lungs. In the ED, the resident was saturating "low" on 4-6 L of oxygen via NC (nasal cannula). ED identified R1 would benefit from using a CPAP when asleep. The resident returned to facility at 2:10 a.m. and was placed on 4 L oxygen pending the revisiting of orders from after visit summary on Monday. The author helped the resident settled in his bed following re-admission and asked how he was doing. With many strong emotions, the resident said "I got bad news. Resident shared with author he had cancer and stated, I feel like I got cheated out of life. I am only 65 years old you know-but looks at me now. I'm a mess." Author comforted resident and notes indicated resident asked author to sit with him and was teary. Currently, the resident is saturating at 82% on 4 L. Author increased oxygen to 5 L NC but that did not make any difference. Author turned tank back to 4 L. The resident refuses for the HOB (head of bed) to be elevated. He was given a PRN dose of his Albuterol puff/Inhaler. -8/25/23 at 12:56 a.m., At approximately 11:30 p.m., R1 began yelling out. R1 was calmed down. However, proceeded to yell out multiple times. Resident refused to put his oxygen on at 12:10 a.m. for this writer stating, "it is on, don't put that thing near me". This writer educated resident on importance of oxygen.	F 684		

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F 684	Continued From page 8 -8/25/23 at 6:57 a.m., Resident refusing to wear oxygen, resident lips cyanotic (blue or livid due to inadequately oxygenated blood), pale face, cool touch in extremities. Resident wanting staff to hold hand, when done he swats hand away. Resident also stating "I'm done, I'm done". Repeated attempts to apply oxygen from various staff failed. -8/25/23 7:23 a.m., identifed the nurse spoke with the on call physician in regards to R1. Direction given to send resident to ED if we felt necessary. However, the ED would do a work up, place on oxygen and send back with no new orders likely. Will request NP to see him ASAP. Son called, left voicemail. -8/25/23 7:50 a.m., Nurse came to social services and gave notification R1 was refusing to wear oxygen about 7:40 a.m. Social services and nurse went and tried to get resident to put oxygen back on. Resident was still refusing. Nurse asked what his name was, date of birth and where he was. Resident was able to recall all questions. Resident was responsive when talking with staff at this time. -8/25/23 at 8:49 a.m., Social services called 911 as directed by nurse. CPR was being given by nurse and a nursing assistant. Social services was then transferred to a hospital representative who stayed on the line until emergency service (EMS) arrived. Once EMS arrived, social services notified the representative an;d then the call was ended. Social services then attempted to contact resident's son, but he did not answer. A voicemail was left. - 8/25/23 at 9:02 a.m., a follow up from the on call	F 684		

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	245367	A. BUILDING _____ B. WING _____	C 09/12/2023

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F 684	Continued From page 9 physician identified "I would not recommend sending him to ED. They will do work up, determine its oxygen he needs, send him back on it. I will have NP see him ASAP."Writer followed providers recommendations. As well as initiated frequent checks every 15 minutes. This writer checked on R1 and determined R1 was not breathing and had no pulse. This writer initiated CPR and instructed staff to call 911. CPR continued for 5 cycles until the ambulance crew arrived in which they applied the chest compressionmachine and took over control. -8/25/23 at 10:38 a.m., time of death called at 8:54 a.m. by ambulance services. R1's medical record lacked evidence of ongoing refusals and interventions related to refusals of oxygen, oxygen saturation levels and vitals on 8/25/23, at 12:56 a.m. until next note on 8/25/23, at 6:57 a.m. (6 hours later) Further, there was no evidence 15 minutes checks were completed. During interview on 9/11/23 at 12:32 p.m., R1's family (F)-A identified R1 was living at the facility for approximately two months and R1 was admitted to the facility with oxygen orders. R1 had many comorbidities but the ultimate goal was to be at the nursing home short term and eventually get him back home with help. R1 never refused his oxygen and typically was more anxious if he was having difficulty breathing and would request additional treatments. When F-A heared R1 refused oxygen the night of 8/25/23, F-A believed R1 was not in his right mind and did not understand why he was not called immediately as, "I can usually get him to do stuff he does not want to do." F-A would have come to the facility or did whatever he needed to because R1	F 684		

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F 684	Continued From page 10 needed oxygen continuously for his health. F-A expressed frustration and stated he communicated to the facility his father had early signs of dementia and when he gets sick he does not think clearly F-A was not called until 6:53 a.m. (nearly 7 hours after R1 started refusing oxygen) on 8/25/23, and a voicemail was left which did not suggest any urgency. Another call was made and a voicemail left at 8:44 a.m. indicating they needed to update him on some information. F-A did not believe R1's oxygen would stay at or near 90%, adding, R1's oxygen would drop if he was not on continuous treatment, "this is difficult for me to believe." During a follow up interview on 9/12/23 at 1:20 p.m., F-A stated he spoke to his father the week leading up to his death adding that he was coherent and stubborn as usual. R1 was asking to call F-B the night before his passing, F-A stated that it sounded like R1 was confused because he never spoke to F-B and would never call him or ask to call him. F-A confirmed his father had a cell phone and did make calls to F-A at times but did also request to call him from the facility phone. F-A confirmed he spoke to NP earlier in the week (was not sure what day) with his father (over the phone) regarding his recent diagnosis and prognosis. NP did not feel his father could make medical decisions and F-A confirmed he agreed and planned to schedule and attend all appointments. Again, F-A wanted to state there would be no way his father's oxygen saturation levels would stay around 90% if he was refusing his oxygen and did not know why the facility did not call him. During interview on 9/11/23 at 8:37 a.m., DON confirmed she was working the evening of	F 684		

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F 684	Continued From page 11 8/24/23, until 3:00 a.m. of 8/25/23. R1 was hollering at lot through out the evening and overnight and would not keep his oxygen on. R1 had refusal of care and often yelled at care givers but he did not have a history of refusing his oxygen. DON stated she was not concerned about the refusing of the medications because his oxygen saturation levels were fine so she did not see any reason to reach out to F-A at that time. DON identified R1's SpO2 was maintaining at or around 90%; however, there was a there was a lack of charting on the DON's part and the last documented SPo2 level was checked at 12:56 a.m. and was 88%. The DON identfied R1's was a lot more antsy in the last week since having been diagnosed with cancer. DON was not alarmed when R1 began refusing his oxygen adding, "[R1] was a particular man; he was cognitively intact and could make his own decisions". During interview on 9/12/23 at 10:49 a.m., registered nurse (RN)-A stated RN-A worked the overnight of 8/25/23, and started her shift at 3:00 a.m. RN-A received report from DON and was informed R1 was not wearing his oxygen and was instructed to just continue to do normal checks. RN-A completed her first round at 3:30 a.m. and R1 appeared normal, was awake and was yelling and asking for F-B (she was not sure who that was). RN-A could hear R1 yelling sometimes but did not see R1 again until around 5:00 a.m. where he appeared the same, still talking loud and still did not have his oxygen on. At 5:30 a.m. RN-A completed a nursing assessment and vitals for R1. RN-A stated she was documenting on a blank piece of paper all night and not in the electronic medical record and R1's SpO2 was 88%; however, this was not reflected in the	F 684		

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F 684	Continued From page 12	F 684		

medical record. At 6:45 a.m. RN-A noticed a change in R1's condition and was able to get him to use oxygen for a short time. RN-A eventually contacted the provider but he did not think R1 needed to go to the ED as they would just try to get him to put on the oxygen too. RN-A did not identify why F-A was not contacted regarding the refusals but stated R1 was maintaining his saturation levels until 7:00 a.m. so it did not seem necessary. RN-A did not work on the nursing home side very often and was not aware of R1's care plan and had not reviewed the care plan on 8/25/23.

On 9/12/23 at 1:20 p.m., nursing assistant (NA)-A stated she was the only nursing assistant working overnight from 8/24/23, to 8/25/23. R1 was awake all night hollering for F-A and F-B. R1 appeared to be uncomfortable with the oxygen on so she offered him foam pieces but he did not want to use those. NA-A could not get R1 to calm down and tried to check on him as often as she could.

During interview on 9/12/23 at 9:40 a.m., NP stated she visited with R1 on 8/23/23, for his follow up visit and contacted F-A during the visit to discuss the ED findings. R1 could not make his own care planning decisions. R1 had no history of refusing his oxygen treatment, though he did have other refusal of care behaviors. NP explained R1 could be oriented to time and place but not have a full cognitive understanding of his prognosis, comorbidities and how his decisions could affect his medical care outcomes. R1's cognitive issues likely played a role in R1's refusals of oxygen on 8/25/23. R1 was impulsive and may not have understood what could be the outcome of that decision. "If it were me, I would

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F 684	Continued From page 13 have attempted to contact the son when he stopped using the oxygen since he could usually step in and talk to him." During interview on 9/12/23 at 3:03 p.m., administrator indicated following the death of R1 the facility reviewed R1's care leading up to the medical emergency. They determined there were holes in the documentation. The administrator was not aware if the care plan was reviewed as part of their internal investigation. Administrator expected resident's care plans to be implemented, using interventions until one is found to be successful. Administrator expected all staff to document interventions used and all nursing assessments, including vitals and SpO2 for residents which should be recorded in the electronic record. At 6:57 a.m. when R1 was determined to have a change in condition, he would have expected the facility do everything they could for the resident. During a follow up interview on 9/12/23 at 3:48 p.m. DON stated R1 was not directly asked why he did not want to wear his oxygen and indicated he was so agitated, she did not think he would answer. When reviewing R1's after visit summary with DON regarding R1's advanced care planning assessment, DON indicated she did not understand what it meant and because R1 was alert and oriented at the time he was able to make his own decisions. DON spent time with R1 re-educating him on the importance of wearing the oxygen but he had the right to refuse and she could not force him to wear it. The DON was new to the facility and not familiar with R1's care plan regarding medication and refusals and did not review R1's care plan on 8/25/23, and was not aware of the care planned interventions to	F 684		

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F 684	Continued From page 14 contact F-A is R1 was refusing care or treatment. F-A was contacted, just not until there was a change in condition. The DON stated staff would need to continue to keep trying the least intrusive interventions until something worked. Although RN-A and DON stated they were completing vital signs and monitoring R1, the medical record lacked evidence this was completed. A policy on nursing assessment related to nursing care planning and assessment was requested but not received.	F 684		

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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 9/11/23 to 9/12/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey. H53675149C (MN96474) H53675247C (MN96680) H53675424C (MN85838) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		