DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 21, 2020

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: CCN: 245499
Cycle Start Date: October 8, 2020

Dear Administrator:

On October 23, 2020, we notified you a remedy was imposed. On November 19, 2020 the Minnesota Department(s) 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 November 2, 2020.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 8, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 23, 2020, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 8, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Electronically Submitted
October 23, 2020

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: CCN: 245499
Cycle Start Date: October 8, 2020

Dear Administrator:

On October 8, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 8, 2020, the situation of immediate jeopardy to potential health and safety cited at F0760 was removed. It was determined that the facility had implemented actions to correct F0600. As a result, the immediate jeopardy was removed and cited as past non-compliance.

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 listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 8, 2021, (42 CFR 488.417 (b)).

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our

recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 8, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 8, 2021, (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Caledonia Rehabilitation & Retirement Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 8, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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 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 April 8, 2021 (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 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

(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 10/7/20 and 10/8/20 an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint H5499036Cwas substantiated at F760, for past non-compliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Complaint H5499037C was substantiated at F725. The past noncompliance IJ began on 10/2/2020 when R1 was incorrectly administered insulin causing R1 to become unresponsive with a blood glucose of 27. The IJ was removed by 10/6/2020 after facility implemented corrective actions. The administrator, DON and registered nurse (RN)-C were notified of the IJ on 10/8/2020, at 8:31 a.m. In addition, an extended survey was completed on 10/8/2020. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000	Past noncompliance: no plan of correction required.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		11/2/20

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

Electronically Signed | 11/02/2020

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 725	Continued From page 1 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to answer call lights timely in order to meet resident physical needs and a psychosocial sense of security which had the potential to affect all 35 residents residing in the facility who use a call-light independently or with assist from visitor. Findings include:	F 725	R4 No Longer Resides in Facility R1 No longer Resides in Facility R5 Interviewed by Social Services 10/28/20 he states: Resident confirms no negative outcomes. Resident has concerns about the call light response times by staff. New Custom Goal -Social Services	

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F 725	Continued From page 2 R4's CEP (common entry point) report dated 9/22/2020 included the facility, "hasn't been answering [R4's] call lights." During a telephone interview with discharged resident (R4) on 10/8/2020, at 9:20 a.m. R4 stated he had call light concerns especially at night. R4 stated staff did not respond to the call light so he was taking himself to the bathroom when he should have had help. R4 stated he waited more than 15 minutes and then he had to get up to the bathroom. R4 stated when he was finished in the bathroom he would shut the call light off after no staff came to help. R4 stated, "Why keep it [the call light] on when it does not do you any good." R4's admission record indicated diagnoses included displaced fracture of the left femur and polyneuropathy. R4's BIMS (brief interview for mental score) assessment dated 9/29/20 indicated R4 was cognitively intact with a score of 13. R4's Daily Skilled Summary dated 10/1/20 indicated R4 required extensive assist of one staff for bed mobility, transfers, walk in the room, dressing, toileting and personal hygiene. R4's activities of daily living (ADL) care plan indicated, "I have an ADL self-care performance deficit r/t. R4's interventions included, "TOILET USE: I require 1 staff participation to use toilet. TOILET USE: I require assistance to wash hands, adjust clothing, clean self, transfer onto toilet and transfer off toilet. TRANSFER: I require 1 staff participation with transfers, and walking	F 725	updated care plan Resident will not experience negative psychological impacts related to call light response times. New Custom Intervention Call light audit will be completed up to 3 times a week by staff. Social Work will check in with resident once a week for 1 month and PRN thereafter regarding call light response time and will document outcome. Residents were interviewed and observed by the IDT to determine if any were affected by the staffing or call lite response time. Residents needs were met and no voiced concerns. Call Light Response Policy was reviewed on 10/16/20 QAPI Reviewed and approved by team and Medical Director. Call Light Audits 4 times per week for 3 weeks by DON. Weekly Audits by Administrator for 2 weeks Education completed for staff regarding reduction of call light times. During Staff meetings Held on 10/21/20 and 10/22/20 All staff will receive this education by 11-2-20 or before they work their next scheduled shift. Call Light Pledge signed by all Employees either during staff meeting or while on shift. Will complete prior to next shift.	

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F 725	Continued From page 3 with walker." R4's call lights were reviewed from 9/29/2020 through 10/6/2020 and revealed the following (call light response times beyond a fifteen-minute threshold are shown): Bedside: -Greater than 15 minutes 7 times, Greater than 20 minutes 5 times, Greater than 25 minutes 1 time, Greater than 40 minutes 2 times. Bathroom: -Greater than 15 minutes 2 times, Greater than 20 minutes 1 time. R1 During an interview on 10/7/20, at 9:39 a.m. R1 stated there was not enough help here and stated she has had to wait for help. R1 stated when she was in a room on the 400 hall she was told not to get up on own. R1 stated on all shifts have to wait half hour or more. R1 stated she asked recently for water and it took thirty minutes to bring back. R1's Admission Record, identified diagnoses included: type 2 diabetes mellitus with hyperglycemia, peripheral vascular disease, and chronic kidney disease. R1's admission Minimum Data Set (MDS) assessment dated 9/28/20 identified R1 to have moderate cognitive impairment and required extensive assistance of one staff for activities of daily living with the exception of eating for which R1 required supervision. R1's activities of daily living (ADL) care plan	F 725	Audits: IDT will conduct a minimum of 3 audits per week for the next four weeks. Any outside the parameter will result in on the spot reeducation of the direct care giver/IDT member with the expectation expressed and any barriers to compliance will be addressed by NHA. Resident Council add to November Agenda via Activities Department. Results of the call light audits will be reported to the QA&A Committee with revisions to the plan as deemed necessary by the QA&A Committee. The Quality Assurance Process Improvement Committee Consists of: Administrator Director of Nursing Clinical Coordinator Social Worker Activities Director Infection Preventionist Business Office Manager Physicians Assistant Medical Director	

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F 725	Continued From page 4 indicated, "I have an ADL self-care performance deficit r/t. R1's interventions included, "TOILET USE: I require 1 staff participation to use toilet. TOILET USE: I require assistance to wash hands, adjust clothing, clean self, transfer onto toilet and transfer off toilet. TRANSFER: I am independent with walking in the facility with 2 ww [wheeled walker] updated 10/4/20." R1's call lights were reviewed from 9/24/2020 through 10/7/2020 and revealed the following (call light response times beyond a fifteen-minute threshold are shown): Bedside: -Greater than 15 minutes 3 times, Greater than 25 minutes 2 times, Greater than 40 minutes 1 time. R5 During an interview on 10/8/20, at 930 a.m. R5 stated he was able to use the call light to call for help. R5 stated sometimes in the nighttime, he has had to wait awhile for someone to help and gets difficult to hold it. R5 stated he has waited twenty minutes or more to have his call light answered. R5's Admission Record, identified diagnoses included: type 2 diabetes mellitus with foot ulcer and mild cognitive impairment. R5's admission Minimum Data Set (MDS) assessment dated 7/8/20 identified R5 to have intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing and toileting.	F 725		

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F 725	Continued From page 5 R5's activities of daily living (ADL) care plan indicated, "The resident has an ADL self-care performance deficit r/t [related to] activity intolerance, impaired balance. "TOILET USE: The resident requires 1 staff for toileting using commode. Transfers: The resident requires 2 staff to move between surfaces with hoyer lift. Use 2 sheep skin pads between him and the hoyer sheet to protect behind his upper thighs-soft side to skin. R5's call lights were reviewed from 9/1/2020 through 10/7/2020 and revealed the following (call light response times beyond a fifteen-minute threshold are shown): September 2020 Bedside: -Greater than 15 minutes 10 times, Greater than 20 minutes 6 times, Greater than 25 minutes 7 time, Greater than 50 minutes 1 time, Greater than 60 minutes 1 time. From 10/1/2020 to 10/7/2020: -Greater than 15 minutes 4 times, Greater than 20 minutes 2 times, Greater than 40 minutes 1 time. During an interview on 10-8-20, at 2:38 p.m. the director of nursing (DON) stated it was everyone's responsibility to answer call lights and the last goal she reviewed was call lights were to be answered in 8 minutes. During an interview on 10/8/2020, at 3:42 p.m. call light reports were reviewed with the administrator for R4, R1 and R5. The	F 725		

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F 725	Continued From page 6 administrator stated, "Oh no, that does not meet expectations for answering call lights." The administrator stated she would say under 15 minutes for sure they should be answered, but under 10 minutes would be more appropriate but we understand that stuff happens. The administrator stated she was ok with 15 minutes for a call light to be answered, but she did not like to see it a lot. The administrator stated anybody can answer a call light that does not mean you can do what the residents requests. The administrator stated if unable to help them, staff can go find somebody to help the resident and that would be the expectation for all of the team. The administrator stated she was aware of the call light concerns as one of the first things she did when she started was run a whole building call light report. The administrator stated the call light response times from their audit were unacceptable. The administrator stated we brought it (call light concerns) to QAPI (quality assurance performance improvement) meeting on Wednesday and we developed a committee to address call light concerns. The administrator stated we also discussed at the staff meeting last Thursday concerns with the call lights. A policy and procedure on call light response times was requested and not provided.	F 725		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 760	Past noncompliance: no plan of	11/2/20

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	245499	A. BUILDING _____ B. WING _____	C 10/08/2020

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F 760	Continued From page 7 facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (R1) reviewed for significant medication errors. R1 physician's orders for insulin administration was not followed. Although noncompliance was present at the time of the event, the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance immediate jeopardy (IJ). The past noncompliance IJ began on 10/2/20 when R1 was incorrectly administered insulin causing R1 to become unresponsive with a blood glucose of 27. The IJ was removed by 10/6/2020 after facility implemented corrective actions. The administrator, director of nursing (DON) and registered nurse (RN)-C were notified of the IJ on 10/8/20, at 8:31 a.m. Findings include: R1's progress note 10/2/20, at 5:50 p.m. included, "Called to resident room by CNA (nursing assistant) delivering supper meal. On assessment resident was in w/c (wheelchair) with head back and not verbally responding. Diaphoretic [sweating, heavily]. Blood sugar obtained and 28. Administered 1 mg (miligram) of Glucagon (treatment for very low blood sugar, severe hypoglycemia) and call placed to on call provider for (medical doctor (MD)-A). Order received to call 911. Additional blood sugar was checked after call for ambulance with reading of 59. Will open eyes when spoken to. On ambulance arrival blood sugar was 67. Rhonchi (lung sounds) heard. [Family member (FM)-A] was called and informed and agreed for ambulance transport. Left via ambulance at	F 760	correction required.	

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F 760	Continued From page 8 1745." A facility Vulnerable Adult report submitted to the State Agency on 10/2/20, indicated R1 received, "Novolog [short acting insulin]12 units given with BS (blood sugar) reading of 107- order reads to hold novolog for BS < (less than)150. BS [blood sugar] recheck at 27- glucagon given. Orders received to send to ED [emergency department]. [FM-A] notified. Recheck of BS [blood sugar] with reading of 59. Recheck prior to transfer 79. Transferred to ...ED [emergency department] via ambulance." R1's Admission Record, identified diagnoses included: type 2 diabetes mellitus with hyperglycemia [high blood sugars], peripheral vascular disease, and chronic kidney disease. R1's admission Minimum Data Set (MDS) assessment dated 9/28/20 identified R1 to have moderate cognitive impairment and required extensive assistance of one staff for activities of daily living with the exception of eating for which R1 required supervision. The MDS also indicated R1 required insulin injections daily during the assessment period. R1's care plan included, "I have Diabetes Mellitus type 2. Interventions: Administer medications as ordered and monitor for adverse effects ..." R1's physician order dated 10/1/2020 included, "NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject 12 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA hold if BS [blood sugar] < 150."	F 760		

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F 760	Continued From page 9 R1's progress note 10/2/2020 at 3:18 p.m. Included, Note Text: Special visit with [physician assistant (PA)] via in touch re[reason] Diabetes type II. Orders, vitals, weight reviewed. See dictated note for full findings. Orders received for levemir 20 units SQ AM and 15 units SQ PM. Add novolog 12 units with meals, hold if BS < 150 ..." R1's medication administration record (MAR) revealed the following: -10/2/20, at 7:30 a.m. R1's blood sugar was 90 and R1's insulin was given. -10/2/20, at 11:00 a.m. R1's blood sugar was 145 and R1's insulin was given. -10/2/20, at 4:00 p.m. R1's blood sugar was 107 and R1's insulin was given. According to physician orders each of the BS were below 150 and insulin should have been held. During an interview on 10/7/20 at 9:49 a.m., R1 stated the staff made a mistake with her insulin and she had to be taken to the emergency room by ambulance. R1 further explained the staff gave her insulin when they weren't supposed and her blood sugar level was 27. R1 stated she could normally tell when her blood sugar levels are high or low but doesn't even recall that day. During an interview on 10/7/20 at 10:11 a.m., licensed practical nurse (LPN)-A stated blood sugar levels are checked prior to meals and bedtime or as ordered by physician. LPN-A stated insulin was given within 30 minutes of eating a meal or after depending on how the resident eats. LPN-A stated she was orientating	F 760		

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LPN-D on 10/2/20 and it was LPN-D's third day of orientation. LPN-A stated LPN-D was an agency nurse and had told her he was familiar with the computer system, checking blood sugar levels, and administering insulin. LPN-A stated she was doing an admission and delegated LPN-D to do the blood sugar checks and insulin administrations. LPN-A stated LPN-D gave R1 the short acting insulin when R1's blood sugar level was below 150 and it should have been held according to her physician orders. LPN-A stated LPN-D was no longer working with their facility since that day. LPN-A stated nursing staff recently received education and the new process was to verify the insulin order and dose with another nurse prior to administration.

During an interview on 10/7/20 at 11:22 a.m., LPN-B stated he was an agency nurse and had worked at facility for about 9 months. LPN-B stated that he had recently received education regarding diabetic care and medication orders. LPN-B stated the new process was to have another nurse verify the order and dose of insulin prior to administration. LPN-B stated he followed the physician orders as far as blood sugar checks, and when insulin should be administered. LPN-B stated if insulin ordered prior to meals that he makes sure it was in within 15-30 minutes of resident eating. LPN-B stated if the blood sugar level was low, he would offer juice and snack.

During an interview on 10/7/20, at 11:36 a.m. RN-B stated he was an agency nurse that had worked at facility for a few weeks. RN-B stated he had recent education on diabetic care and medication orders this past week. RN-B stated

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F 760	Continued From page 11	F 760		

the charge nurse does the blood sugar checks and insulin and now they have another nurse verify the insulin order and dose before administering.

During an interview on 10/7/20, at 2:58 p.m. LPN-C stated she received education on diabetic care and physician orders. LPN-C stated the new process was to have another nurse verify the order and dose prior to administration. LPN-C stated she would bring up the order in the computer system to verify the order then the dose to be given. LPN-C stated they are currently using paper chart to document the verification with the initials of the two nursing staff. LPN-C stated blood sugar checks are done prior to meals and bedtime if ordered. LPN-C stated order changes are communicated directly from the nurse receiving or a note was usually left on the cart.

An attempt to interview LPN-D by phone was made on 10/7/20 at 3:45 p.m. LPN-D did not answer so a message was left requesting a return call. No return call was received on 10/7/20 or 10/8/20.

During an interview on 9/7/20, at 5:03 p.m. the DON and RN-C stated on 10/2/20, LPN-D did not read the instructions on the MAR correctly, the insulin should have been held at blood sugars less than 150, and it was not. RN-C stated we looked at all residents who received insulin to see if they received the insulin according to orders. RN-C stated we wanted to rule out any other residents were effected and that they were stable and stated there were four residents on insulin in the facility. RN-C stated we did

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F 760	Continued From page 12 immediate education to all nurses and the medication technicians on medication administration and diabetic management education. RN-C stated all education was started on 10-2-20 and was completed as of 10/6/20. RN-C stated we are also auditing doctor orders, the MAR and are competing observations of nursing drawing up insulin daily. RN-C stated they implemented two staff verification of correct blood sugar against the orders, against the MAR for the parameters and the actual drawing up of the insulin. The DON and RN-C verified on 10/2/20, the 7:30 a.m., 11:00 a.m. and 4:00 p.m. blood sugars were all below 150 however, documentation reflected on the medication administration record (MAR) reflected the insulin was administered to R1 anyway. RN-C stated in LPN-D's written statement LPN-D indicated he was not aware of the insulin order change on 10/1/20 and stated they have been trying to reach LPN-D for further interview. The facility's Administering Medications policy dated April 2019 included, "4. Medications are administered in accordance with prescriber orders, including any required time frame." The IJ was removed and the deficient practice was corrected by 10/6/20, after the facility had recognized, developed and implemented a plan that included re-education to nurses and medication technicians on proper components of medication administration, all nurses received re-education on diabetic management, and the DON initiated monitoring to ensure two nurses were signing off to verify blood sugars against the MAR, to ensure the correct amount of insulin is drawn up when applicable, to verify provider	F 760		

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F 760	Continued From page 13 notification in accordance with parameters identified. In addition, the DON initiated a system to review all new admit/re-admit orders for accuracy to ensure they were put into the electronic record system (point click care) correctly including any "Call parameters" and "Hold orders". Because the facility had implemented these appropriate measures, and it was verified they had been implemented prior to survey, the deficiency is being cited at past non-compliance.	F 760		

Electronically delivered
October 23, 2020

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

Re: State Nursing Home Licensing Orders
Event ID: 01XL11

Dear Administrator:

The above facility was surveyed on October 7, 2020 through October 8, 2020 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:

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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

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

Please feel free to call me with any questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On 10/7/2020 and 10/8/2020 surveyors of this Department's staff conducted complaint investigations. Complaints investigated: H5499036C was substantiated and cited as IJ past non-compliance. H5499037C was substantiated and a deficiency was cited at MN Rule 4658.1320A.B.C.. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to answer call lights timely in order to meet resident physical needs and a psychosocial sense of security which had the potential to affect all 35 residents residing in the facility who use a call-light independently or with assist from visitor. Findings include: R4's CEP (common entry point) report dated 9/22/2020 included the facility, "hasn't been answering [R4's] call lights."	2 800	Corrected.	11/2/20

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2 800	Continued From page 3 During a telephone interview with discharged resident (R4) on 10/8/2020, at 9:20 a.m. R4 stated he had call light concerns especially at night. R4 stated staff did not respond to the call light so he was taking himself to the bathroom when he should have had help. R4 stated he waited more than 15 minutes and then he had to get up to the bathroom. R4 stated when he was finished in the bathroom he would shut the call light off after no staff came to help. R4 stated, "Why keep it [the call light] on when it does not do you any good." R4's admission record indicated diagnoses included displaced fracture of the left femur and polyneuropathy. R4's BIMS (brief interview for mental score) assessment dated 9/29/20 indicated R4 was cognitively intact with a score of 13. R4's Daily Skilled Summary dated 10/1/20 indicated R4 required extensive assist of one staff for bed mobility, transfers, walk in the room, dressing, toileting and personal hygiene. R4's activities of daily living (ADL) care plan indicated, "I have an ADL self-care performance deficit r/t. R4's interventions included, "TOILET USE: I require 1 staff participation to use toilet. TOILET USE: I require assistance to wash hands, adjust clothing, clean self, transfer onto toilet and transfer off toilet. TRANSFER: I require 1 staff participation with transfers, and walking with walker." R4's call lights were reviewed from 9/29/2020 through 10/6/2020 and revealed the following (call light response times beyond a fifteen-minute	2 800		

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(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) COMPLETE DATE
2 800	Continued From page 4 threshold are shown): Bedside: -Greater than 15 minutes 7 times, Greater than 20 minutes 5 times, Greater than 25 minutes 1 time, Greater than 40 minutes 2 times. Bathroom: -Greater than 15 minutes 2 times, Greater than 20 minutes 1 time. R1 During an interview on 10/7/20, at 9:39 a.m. R1 stated there was not enough help here and stated she has had to wait for help. R1 stated when she was in a room on the 400 hall she was told not to get up on own. R1 stated on all shifts have to wait half hour or more. R1 stated she asked recently for water and it took thirty minutes to bring back. R1's Admission Record, identified diagnoses included: type 2 diabetes mellitus with hyperglycemia, peripheral vascular disease, and chronic kidney disease. R1's admission Minimum Data Set (MDS) assessment dated 9/28/20 identified R1 to have moderate cognitive impairment and required extensive assistance of one staff for activities of daily living with the exception of eating for which R1 required supervision. R1's activities of daily living (ADL) care plan indicated, "I have an ADL self-care performance deficit r/t. R1's interventions included, "TOILET USE: I require 1 staff participation to use toilet. TOILET USE: I require assistance to wash hands, adjust clothing, clean self, transfer onto toilet and transfer off toilet. TRANSFER: I am	2 800		

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	00073	A. BUILDING: _____ B. WING _____	C 10/08/2020

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2 800	Continued From page 5 independent with walking in the facility with 2 ww [wheeled walker] updated 10/4/20." R1's call lights were reviewed from 9/24/2020 through 10/7/2020 and revealed the following (call light response times beyond a fifteen-minute threshold are shown): Bedside: -Greater than 15 minutes 3 times, Greater than 25 minutes 2 times, Greater than 40 minutes 1 time. R5 During an interview on 10/8/20, at 930 a.m. R5 stated he was able to use the call light to call for help. R5 stated sometimes in the nighttime, he has had to wait awhile for someone to help and gets difficult to hold it. R5 stated he has waited twenty minutes or more to have his call light answered. R5's Admission Record, identified diagnoses included: type 2 diabetes mellitus with foot ulcer and mild cognitive impairment. R5's admission Minimum Data Set (MDS) assessment dated 7/8/20 identified R5 to have intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing and toileting. R5's activities of daily living (ADL) care plan indicated, "The resident has an ADL self-care performance deficit r/t [related to] activity intolerance, impaired balance. "TOILET USE: The resident requires 1 staff for toileting using commode. Transfers: The resident requires 2	2 800		

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2 800	Continued From page 6 staff to move between surfaces with hoyer lift. Use 2 sheep skin pads between him and the hoyer sheet to protect behind his upper thighs-soft side to skin. R5's call lights were reviewed from 9/1/2020 through 10/7/2020 and revealed the following (call light response times beyond a fifteen-minute threshold are shown): September 2020 Bedside: -Greater than 15 minutes 10 times, Greater than 20 minutes 6 times, Greater than 25 minutes 7 time, Greater than 50 minutes 1 time, Greater than 60 minutes 1 time. From 10/1/2020 to 10/7/2020: -Greater than 15 minutes 4 times, Greater than 20 minutes 2 times, Greater than 40 minutes 1 time. During an interview on 10-8-20, at 2:38 p.m. the director of nursing (DON) stated it was everyone's responsibility to answer call lights and the last goal she reviewed was call lights were to be answered in 8 minutes. During an interview on 10/8/2020, at 3:42 p.m. call light reports were reviewed with the administrator for R4, R1 and R5. The administrator stated, "Oh no, that does not meet expectations for answering call lights." The administrator stated she would say under 15 minutes for sure they should be answered, but under 10 minutes would be more appropriate but we understand that stuff happens. The administrator stated she was ok with 15 minutes for a call light to be answered, but she did not like	2 800		

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2 800	Continued From page 7 to see it a lot. The administrator stated anybody can answer a call light that does not mean you can do what the residents requests. The administrator stated if unable to help them, staff can go find somebody to help the resident and that would be the expectation for all of the team. The administrator stated she was aware of the call light concerns as one of the first things she did when she started was run a whole building call light report. The administrator stated the call light response times from their audit were unacceptable. The administrator stated we brought it (call light concerns) to QAPI (quality assurance performance improvement) meeting on Wednesday and we developed a committee to address call light concerns. The administrator stated we also discussed at the staff meeting last Thursday concerns with the call lights. A policy and procedure on call light response times was requested and not provided. SUGGESTED METHOD FOR CORRECTION: (1) Re-evaluate staffing assignments of nursing assistants. (2) Develop and implement a staffing plan which ensures that each resident's individualized needs are addressed and met; educate all staff. (3) Develop and implement a system which ensures appropriate supervision of resident care. (4) Track and trend incidents and resident complaints, which may identify those personnel who need re-education or corrective action. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 800		

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21545	Continued From page 8	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		11/2/20

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21545	Continued From page 9 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (R1) reviewed for significant medication errors. R1 physician's orders for insulin administration was not followed. Although noncompliance was present at the time of the event, the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance immediate jeopardy (IJ). The past noncompliance IJ began on 10/2/20 when R1 was incorrectly administered insulin causing R1 to become unresponsive with a blood glucose of 27. The IJ was removed by 10/6/2020 after facility implemented corrective actions. The administrator, director of nursing (DON) and registered nurse (RN)-C were notified of the IJ on 10/8/20, at 8:31 a.m. Findings include: R1's progress note 10/2/20, at 5:50 p.m. included, "Called to resident room by CNA (nursing assistant) delivering supper meal. On assessment resident was in w/c (wheelchair) with head back and not verbally responding. Diaphoretic [sweating, heavily]. Blood sugar obtained and 28. Administered 1 mg (miligram) of	21545	corrected	

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21545	Continued From page 10	21545		

Glucagon (treatment for very low blood sugar, severe hypoglycemia) and call placed to on call provider for (medical doctor (MD)-A). Order received to call 911. Additional blood sugar was checked after call for ambulance with reading of 59. Will open eyes when spoken to. On ambulance arrival blood sugar was 67. Rhonchi (lung sounds) heard. [Family member (FM)-A] was called and informed and agreed for ambulance transport. Left via ambulance at 1745."

A facility Vulnerable Adult report submitted to the State Agency on 10/2/20, indicated R1 received, "Novolog [short acting insulin]12 units given with BS (blood sugar) reading of 107- order reads to hold novolog for BS < (less than)150. BS [blood sugar] recheck at 27- glucagon given. Orders received to send to ED [emergency department]. [FM-A] notified. Recheck of BS [blood sugar] with reading of 59. Recheck prior to transfer 79. Transferred to ...ED [emergency department] via ambulance."

R1's Admission Record, identified diagnoses included: type 2 diabetes mellitus with hyperglycemia [high blood sugars], peripheral vascular disease, and chronic kidney disease.

R1's admission Minimum Data Set (MDS) assessment dated 9/28/20 identified R1 to have moderate cognitive impairment and required extensive assistance of one staff for activities of daily living with the exception of eating for which R1 required supervision. The MDS also indicated R1 required insulin injections daily during the assessment period.

R1's care plan included, "I have Diabetes Mellitus

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21545	Continued From page 11 type 2. Interventions: Administer medications as ordered and monitor for adverse effects ..." R1's physician order dated 10/1/2020 included, "NovoLOG Solution 100 UNIT/ML (Insulin Aspart) Inject 12 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA hold if BS [blood sugar] < 150." R1's progress note 10/2/2020 at 3:18 p.m. Included, Note Text: Special visit with [physician assistant (PA)] via in touch re[reason] Diabetes type II. Orders, vitals, weight reviewed. See dictated note for full findings. Orders received for levemir 20 units SQ AM and 15 units SQ PM. Add novolog 12 units with meals, hold if BS < 150 ..." R1's medication administration record (MAR) revealed the following: -10/2/20, at 7:30 a.m. R1's blood sugar was 90 and R1's insulin was given. -10/2/20, at 11:00 a.m. R1's blood sugar was 145 and R1's insulin was given. -10/2/20, at 4:00 p.m. R1's blood sugar was 107 and R1's insulin was given. According to physician orders each of the BS were below 150 and insulin should have been held. During an interview on 10/7/20 at 9:49 a.m., R1 stated the staff made a mistake with her insulin and she had to be taken to the emergency room by ambulance. R1 further explained the staff gave her insulin when they weren't supposed and her blood sugar level was 27. R1 stated she could normally tell when her blood sugar levels are high or low but doesn't even recall that day.	21545		

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21545	Continued From page 12 During an interview on 10/7/20 at 10:11 a.m., licensed practical nurse (LPN)-A stated blood sugar levels are checked prior to meals and bedtime or as ordered by physician. LPN-A stated insulin was given within 30 minutes of eating a meal or after depending on how the resident eats. LPN-A stated she was orientating LPN-D on 10/2/20 and it was LPN-D's third day of orientation. LPN-A stated LPN-D was an agency nurse and had told her he was familiar with the computer system, checking blood sugar levels, and administering insulin. LPN-A stated she was doing an admission and delegated LPN-D to do the blood sugar checks and insulin administrations. LPN-A stated LPN-D gave R1 the short acting insulin when R1's blood sugar level was below 150 and it should have been held according to her physician orders. LPN-A stated LPN-D was no longer working with their facility since that day. LPN-A stated nursing staff recently received education and the new process was to verify the insulin order and dose with another nurse prior to administration. During an interview on 10/7/20 at 11:22 a.m., LPN-B stated he was an agency nurse and had worked at facility for about 9 months. LPN-B stated that he had recently received education regarding diabetic care and medication orders. LPN-B stated the new process was to have another nurse verify the order and dose of insulin prior to administration. LPN-B stated he followed the physician orders as far as blood sugar checks, and when insulin should be administered. LPN-B stated if insulin ordered prior to meals that he makes sure it was in within 15-30 minutes of resident eating. LPN-B stated if the blood sugar level was low, he would offer	21545		

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21545	Continued From page 13 juice and snack. During an interview on 10/7/20, at 11:36 a.m. RN-B stated he was an agency nurse that had worked at facility for a few weeks. RN-B stated he had recent education on diabetic care and medication orders this past week. RN-B stated the charge nurse does the blood sugar checks and insulin and now they have another nurse verify the insulin order and dose before administering. During an interview on 10/7/20, at 2:58 p.m. LPN-C stated she received education on diabetic care and physician orders. LPN-C stated the new process was to have another nurse verify the order and dose prior to administration. LPN-C stated she would bring up the order in the computer system to verify the order then the dose to be given. LPN-C stated they are currently using paper chart to document the verification with the initials of the two nursing staff. LPN-C stated blood sugar checks are done prior to meals and bedtime if ordered. LPN-C stated order changes are communicated directly from the nurse receiving or a note was usually left on the cart. An attempt to interview LPN-D by phone was made on 10/7/20 at 3:45 p.m. LPN-D did not answer so a message was left requesting a return call. No return call was received on 10/7/20 or 10/8/20. During an interview on 9/7/20, at 5:03 p.m. the DON and RN-C stated on 10/2/20, LPN-D did not read the instructions on the MAR correctly, the insulin should have been held at blood sugars less than 150, and it was not. RN-C stated we	21545		

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21545	Continued From page 14 looked at all residents who received insulin to see if they received the insulin according to orders. RN-C stated we wanted to rule out any other residents were effected and that they were stable and stated there were four residents on insulin in the facility. RN-C stated we did immediate education to all nurses and the medication technicians on medication administration and diabetic management education. RN-C stated all education was started on 10-2-20 and was completed as of 10/6/20. RN-C stated we are also auditing doctor orders, the MAR and are competing observations of nursing drawing up insulin daily. RN-C stated they implemented two staff verification of correct blood sugar against the orders, against the MAR for the parameters and the actual drawing up of the insulin. The DON and RN-C verified on 10/2/20, the 7:30 a.m., 11:00 a.m. and 4:00 p.m. blood sugars were all below 150 however, documentation reflected on the medication administration record (MAR) reflected the insulin was administered to R1 anyway. RN-C stated in LPN-D's written statement LPN-D indicated he was not aware of the insulin order change on 10/1/20 and stated they have been trying to reach LPN-D for further interview. The facility's Administering Medications policy dated April 2019 included, "4. Medications are administered in accordance with prescriber orders, including any required time frame." The IJ was removed and the deficient practice was corrected by 10/6/20, after the facility had recognized, developed and implemented a plan that included re-education to nurses and medication technicians on proper components of medication administration, all nurses received	21545		

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21545	Continued From page 15 re-education on diabetic management, and the DON initiated monitoring to ensure two nurses were signing off to verify blood sugars against the MAR, to ensure the correct amount of insulin is drawn up when applicable, to verify provider notification in accordance with parameters identified. In addition, the DON initiated a system to review all new admit/re-admit orders for accuracy to ensure they were put into the electronic record system (point click care) correctly including any "Call parameters" and "Hold orders". Because the facility had implemented these appropriate measures, and it was verified they had been implemented prior to survey, the deficiency is being cited at past non-compliance. SUGGESTED METHOD OF CORRECTION: Because the deficiency was cited at PAST NON-COMPLIANCE, no method of correction is necessary.	21545		