Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 21, 2022

Administrator
Pine View Rehabilitation And Senior Living
425 North Badger Street
Caledonia, MN 55921

RE: CCN: 245499
Cycle Start Date: September 28, 2022

Dear Administrator:

On October 17, 2022, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2022

- Civil money penalty. (42 CFR 488.430 through 488.444)

On November 3, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2022, will remain in effect.

This Department continues to recommend 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 October 29, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 2022.

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.

As CMS notified you in letter of October 17, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years September 28, 2022.

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
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
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 28, 2023 (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

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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November 21, 2022

Administrator
Pine View Rehabilitation And Senior Living
425 North Badger Street
Caledonia, MN 55921

Re: State Nursing Home Licensing Orders
Event ID: BDKR11

Dear Administrator:

The above facility was surveyed on November 2, 2022 through November 3, 2022 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, RN, Unit Supervisor
Rochester District Office
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
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING ______ B. WING ______	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VIEW REHABILITATION AND SENIOR LIVING	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 11/2/22 through 11/3/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54995219C (MN86790), with a deficiency cited at F725 with a related deficieny cited at F842. 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 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §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	F 725		12/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 11/29/2022

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 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 observation, interview and record review, the facility failed to ensure a licensed practical nurse or a registered nurse was in the facility at all times to provide skilled nursing cares, daily assessments of resident needs or supervise the work of unlicensed personnel. It was discovered that an unlicensed person administered insulin to 4 of 4 residents (R2,R4, R5,R7), administered crushed medications through a gastrostomy tube (G-tube) to 1 of 1 residents (R3) and monitored the status of 1 of 1 residents (R3) who had a tracheostomy(surgically created opening into the trachea for persons who have difficulty breathing or maintaining oxygen levels through the mouth/nose) and oxygen dependent. Findings include: According to R2's annual Minimum Data Set (MDS) assessment dated 8/19/22, R2 was	F 725	To Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Residents (R2,R4, R5,R7,R3,) were assessed by the Registered nurse and their status was monitored for 72 hours , no adverse reactions were noted, no individual developed any signs or symptoms that may indicate a change in condition. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 2 All Current residents have the potential to be affected and are all at risk from the deficient practice. Upon observations no other residents were found to have been affected.	

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F 725	Continued From page 2 cognitively intact; marked as medically complex with diagnosis of traumatic brain injury, paraplegia and diabetes mellitus among other co-morbidities. According to R3's quarterly MDS assessment dated 9/2/22, R3 was unable to respond to any cognitive assessment and staff indicated R3 was severely impaired. R3 had a primary diagnosis of traumatic brain dysfunction, quadriplegia, traumatic brain injury, a seizure disorder and had a tracheotomy. MDS also indicated R3 had a G-tube and required tube feedings. According to R4's quarterly MDS assessment dated 9/9/22, R4 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as being cognitively intact in January of 2022). R4 was marked as medically complex with a diagnosis of diabetes mellitus, malnutrition, a history of a stroke and other comorbidities. According to R5's quarterly MDS assessment dated 8/20/22, R5 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as moderately cognitively impaired 12/7/21). R5 was marked as medically complex with a diagnosis of diabetes mellitus, cerebral palsy and hemiplegia, along with other diagnosis. R5 also had renal disease and required dialysis. According to R7's five day MDS assessment dated 10/10/22, R7 was marked as medically complex with a diagnoses of diabetes mellitus, heart failure, malnutrition, chronic respiratory disorder, along with other diagnosis. R7 also had renal disease and required dialysis.	F 725	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 3. The Facility has on-going advertising to hire RNs and LPNs to assist with continuing to provide staffing per the regulatory requirement. The Facility Administrator and the director of nursing will monitor the staffing daily and weekly to ensure the scheduling of RNs and LPNs.In the instance when there is a call-in of nursing staff the facility will attempt to provide coverage with a RN to meet the regulatory requirements. If the facility is unable to schedule a nurse to provide coverage the Director of Nursing will be called in to cover the opening. The Administrator will ensure the building is covered with 8 hours of RN or LPN coverage per shift. The Administrator has also informed the scheduler to do the staffing schedule a month in advance to help with nursing coverage and to plan accordingly. " The Facility has signed two agency contracts to obtain additional Nurses to assist with staffing requirements. " Facility has ongoing recruitment advertising recruiting agency's ,we are also offering incentives with Employee Sign on Bonuses and referral bonuses to assist with the recruitment and hiring of Nurses. 4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, The Administrator or	

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F 725 Continued From page 3

According to physician orders in their medical records, R2, R4, R5 and R7 all required daily injections of insulin to control their blood sugar. R3 required medications be given through a G-tube, as well as supplemental fluids of 300 ml(milliliters) four times daily via (by)G-tube. R3 had orders for constantly humidified oxygen to be supplied through his tracheostomy tube. R3 also had orders to irrigate his Foley catheter if it should become obstructed, and orders to irrigate his rectal tube every four hours and as needed to maintain patency of the tube (R3 required the rectal tube due to having an open sacral wound and a history of infection of the wounds with resulting sepsis).

During an interview on 11/2/2022, at 9:27 a.m. registered nurse (RN)-A stated she was often called on her days off to work additional shifts. RN-A stated the facility had been struggling to have enough staff and stated, "it's getting to the point we are wondering, who will replace me at the end of my shift." RN-A stated she was aware there had been a day when the facility did not have a nurse in the building.

During an interview on 11/2/22, at 9:54 a.m. and follow up interview on 11/3/22, 10:15 a.m. nursing assistant (NA)-A stated she did the scheduling for the nursing department. NA-A stated she usually comes to the facility at 7:00 a.m. on her scheduled work days, but on 10/14/22 was called at home by one of the night shift nurses, RN-B at 6:14 a.m. to notify her the relief nurse, RN-C had not shown up for his scheduled shift. NA-A then called RN-C, and got no answer, then called RN-A about covering the open shift but that call was not answered either. NA-A then called a

F 725

Director of nursing will perform staffing reviews daily and weekly for 3 months, and then Weekly for 3 months .

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
5. The Director of nursing and administrator will monitor the results of their daily and weekly staffing reviews and will present the results of the reviews to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or subsequent plan of correction if modifications are needed.

action will be completed 12/2/22

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F 725		F 725		

Continued From page 4
licensed practical nurse (LPN)-A and left a message at 6:21 a.m. about the need for a nurse. At 6:25 a.m. NA-A called the director of nursing (DON) and left a voice mail concerning RN-C not showing up for work. NA-A then received a call from another night nurse, LPN-B, asking if someone was coming in to replace her. NA-A proceeded to the facility, and at 7:19 a.m. received a call from LPN-A stating she had things to do at home, but would come in sometime after 10 a.m. NA-A stated that RN-B left the facility on the morning of 10/14/22, but she was not sure at what time. NA-A then reported speaking to the DON for eight minutes, but could not recall exactly what they had talked about.

During the interview on 11/2/22, NA-A first stated LPN-B worked until LPN-A arrived, but later stated LPN-B had finished providing wound care to R3 and then went "upstairs to sleep" (there is an attached building with sleeping rooms where some staff stay). NA-A stated LPN-B did not "punch out" and was listed on the schedule as working 6:15 a.m. until 2 p.m. because "LPN-A did not end up picking up the shift.". NA-A tried to reach the regional administrator at 8:46 a.m. and then again at 9:44 a.m. when they spoke for six minutes about NA-A's staffing concerns. At some time after that call, NA-A recalled that LPN-A did come to the building, but decided she was not going to work, and NA-A notified the regional administrator of the situation at 10:12 a.m. but she could not recall exactly what they talked about. NA-A stated there was a nursing assistant, trained medication aid (TMA)-B, who was able to pass oral medications, and later stated she understood TMA-A, who was not scheduled, had come up from her additional job in the laundry to assist. NA-A stated there was not a nurse on-duty

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F 725	Continued From page 5	F 725		

after LPN-B left the building until RN-B returned at around 2:00 p.m.

According to an interview on 11/2/22, 10:25 a.m. TMA-B stated she was scheduled to work on 10/14/22, starting at 6:00 a.m. TMA-B stated, "I remember there wasn't anyone to do the nursing part and everyone was running around like what are we supposed to do? I got late starting on my pills because we were trying to figure out what to do." TMA-A did not know when LPN-B left the facility, but stated she did not see her or any other nurse working from about 8 a.m. until the end of the shift at about 2:00 p.m. when RN-B had returned to duty. TMA-B stated TMA-A was in the building and came to assist with checking morning diabetic blood glucose (BG) levels/blood sugars. TMA-B said she thought TMA-A also gave insulin injections. TMA-B did recall LPN-A coming to the building, but stated LPN-A did not punch in, was observed to be upset and crying and left soon after. TMA-A stated the DON was not in the building on Fridays, Saturdays and Sundays, and had heard staff were not to contact her. TMA-A said "I don't think anyone was in charge"[on 10/14/22].

According to an interview on 11/2/22, at 10:49 a.m. LPN-A stated she had received a call about the open shift on 10/14/22 in the morning, and had told NA-A that she had chores to do and could not come until after 10 a.m. but said she would work. LPN-A stated when she entered the facility TMA-A was in the dining area and said, "thank god, you're here." LPN-A did not see a nurse on duty and went to the social service office as the social service designee (SSD)-A was the only department head LPN-A could find. LPN-A reported the lack of a nurse on duty to SSD-A

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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) COMPLETION DATE
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who told her to call the regional administrator. TMA-A then spoke to NA-A who told her, "I had the night nurse stay punched in when she went up to bed." LPN-A stated she got upset and told NA-A she was not going to stay as she was concerned there had not been a nurse on duty, and she needed to protect her license. LPN-A said she went to tell TMA-A that she was leaving, but found TMA-A struggling with an insulin flex pen (a syringe that holds an insulin vial and is used multiple times for dosing insulin). TMA-A reported she was giving insulin to R2, but 18 units of the dose would not inject, leaving R2 having received only a partial dose. LPN-A was able to intervene, changed the flex pen needle, primed the needle with 2 units and set the dose for the additional 18 units and gave the device back to TMA-A and then left the building. LPN-A stated when she had been called to work, she was not aware she would be the only nurse in the building and she had not been made aware that no nurse would be in the building until she arrived. LPN-A stated insulin should not be given by a TMA-A in a skilled nursing facility. LPN-A stated she did not know what would have happened if there had been an emergency in the building on 10/14/22, "I guess they would have to have called an ambulance."

According to an interview 11/2/22, at 11:12 a.m. SSD-A stated she recalled LPN-A had come to her office on 10/14/22 to tell her she had been called to come in to work, but had not realized she was going to be the only nurse, and did not want to stay. SSD-A stated the staffing coordinator was usually the person who would call the DON or an administrator if there were staffing issues or problems in the nursing department when they were out. SSD-A could not

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recall if any such contact was made on that day, but thought she recalled NA-A letting her know she had either LPN-B or RN-B returning to work the 6 a.m. to 2 p.m. portion of the open shift, and then RN-B was going to work 2:00 p.m. until 6 p.m.

According to an interview on 11/2/22, at 11:21 a.m. the regional director of operations (RDOP) stated she had received a call from the facility on 10/14/22 to notify her the scheduled nurse had not shown up for the day shift, but RDOP stated she thought there was an RN in the attached building sleeping. RDOP also said RN-B was in the building, but did not know at what time. RDOP stated the DON could be called at any time, but she was aware the DON had a personal issue to attend to on 10/14/22 and was not available. RDOP stated the facility could call her with any nursing concerns.

According to an interview on 11/2/22, at 11:31 a.m. the business office manager (BOM) stated an employee is not to stay "punched in" when they are sleeping. BOM reviewed LPN-B's computerized time sheet which indicated she had documented hours of work starting on 10/13/22 at 6 p.m. through 6 a.m. on 10/14/22 and then documented hours of work starting at 6:15 a.m. on 10/14/22 through 2:00 p.m. BOM then recalled that LPN-B was a new employee and had probably been writing her hours worked on a time sheet form rather than punching the time clock. BOM located the hand written, signed document that indicated LPN-B had worked from 10/13/22, 6 p.m. through 10/14/22, 8:00 a.m. The record indicated LPN-B was scheduled to work until 6:00 a.m. on 10/14/22, but had stayed an additional two hours. BOM was unable to say why the

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F 725	Continued From page 8 computer hours did not match the written/signed document from LPN-B. According to an interview on 11/02/22, at 11:38 a.m. the DON stated she works in the building Monday through Thursday and works remotely on Fridays; however, staff should call her with any nursing concerns they are unable to handle. DON stated she was not available after about 8:15 a.m. on 10/14/22 as she had a personal emergency, but said she had received a call earlier at about 6:27 a.m. from NA-A regarding RN-C not showing up for his scheduled shift, but DON was unable to recall anymore from that day. The facility DON stated she recently had shared the expected standards for nurse staffing with the facility's new administrator, and stated the ideal for the building was to have an RN charge nurse and an LPN, plus two TMAs to pass medications on a day shift. DON stated the minimum nurse staffing would be to have an RN and two TMAs. DON stated currently the facility did not have an RN designated on-call if there was not one in the building as they usually could contact her or someone from the corporate office. The DON stated the facility provided sleeping quarters for some of the nurses, and depending on their contract, they were considered to be a facility resource who could be called upon at any time to come to the building "if they were available." DON stated if they had other commitments they were not required to come to the building to work if called. DON also stated the nurses were not to remain "punched in" if they were out of the building and in the sleeping quarters.	F 725		

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According to an interview on 11/2/22, at 12:58 p.m. LPN-B stated she was aware, on 10/14/22, that the RN scheduled to replace her in the morning had not shown up for work. LPN-B stated she "stayed a little late to finish charting" on that day. LPN-B stated she had "attended to the needs of the patients", but would not confirm if she had given any resident their insulin dose, and stated she did not know why the insulin doses were signed off as having been given by a different nurse. LPN-B stated she had seen TMA-A and TMA-B in the building and said they were both passing medications, but she did not know if TMA-A was able to give insulin in her role or not. LPN-B stated she had not told anyone when she left the building to go to the sleeping area as "I understood another nurse was coming in to replace me." LPN-B stated she did not know if her replacement had arrived by the time she left. LPN-B stated she was not using the time-clock at that time as she was quite new, and instead was "signing in and signing out on a time slip [paper]." LPN-B denied knowing the computerized record showed she was working from 6:15 a.m. to 2 p.m. on 10/14/22, and further stated she was not paid when in the sleeping quarters, saying, "when I'm off, I'm off."

According to an interview on 11/2/22, 2:25 p.m. RN-B stated she had been working the overnight shift with LPN-B from 10/13/22 until the morning of 10/14/22. RN-B stated she had been filling the nursing assistant shift. RN-B stated she had been aware that the relief nurse did not show up for his shift on the morning of 10/14/22, but stated she left the building in the morning, thinking it was about 6 a.m. RN-B stated she worked for the corporate entity, but did help fill in some of the work shifts at time, but stayed in a different city.

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F 725	Continued From page 10 RN-B stated she often had poor phone service after leaving the facility, and did not get any communications sent to her about needing a nurse until later in the day, but she was not sure of the time. RN-B stated she had returned to the building later to work a 2 p.m. to 6 p.m. shift, but stated she was not sure when she had entered the building. RN-B stated she did not have access to the time-clock so wrote out her times worked on a paper form that she signed. RN-B stated she had not been in the building when the morning insulin was to be given and could not recall why she had signed off the insulin doses to R2,R4, R5 and R7. RN-B further stated she could not recall why her initials were showing on R3's electronic MAR indicating she had been the one to give his morning medications via g-tube on 10/14/22. RN-B stated she had not given any morning medication and had not done any treatments that morning. RN-B stated she would not administer any morning medications that were marked as late without first assessing the resident's physical condition and whether the medication could be given later than ordered. RN-B stated she could recall that there were a lot of medications showing up in red, meaning they had been missed or were late, and if she had signed them, she "signed in error." RN-B did not recall if there was a nurse in the building when she arrived on 10/14/22 and said she would not have received shift to shift report as it was simply done on a piece of paper and not given nurse to nurse. RN-B stated she did recall staff saying to her, "thank-you for coming in." According to an interview on 11/2/22, 2:41 p.m. DON stated she recalled a conversation she had had with NA-A on 10/14/22 regarding staffing concerns. She recalled being told there were two	F 725		

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TMAs on the schedule, TMA-A and TMA-B. DON stated TMA-A used to be a nurse, but was not any longer. DON stated a TMA was not able to give insulin or do any treatments such as wound care and had never been informed that this had occurred. DON stated she was not aware, at the time, that there had not been a nurse in the building, and said there should have been. DON stated she recalled being told later that LPN-A had come to the building, and had stayed about 30 minutes before leaving. DON stated she understood LPN-A had not stayed because there was not an RN in the building. DON stated an expectation for the RDOP to have been notified, but said she was not sure where the RDOP was on that day or if she would have been able to come to the building.

According to an interview on 11/3/22, 9:29 a.m. TMA-A stated she worked in the facility in the laundry, worked as a nursing assistant and also as a TMA. TMA-A stated she had been an LPN at one time, but it had been, perhaps as long as 8 years since she had practiced. TMA-A stated she no longer does any nursing continuing education. TMA-A stated she was in the building on the laundry schedule on 10/14/22, but also came to the dining room to assist the residents with their breakfast between 8 a.m. and 8:30 a.m. TMA-A stated NA-A told her LPN-B had been providing some cares to R3, and then was going to go to the sleeping quarters and there was not a nurse in the building. TMA-A stated she did not see LPN-B that morning. TMA-A stated NA-A told her she was unable to locate a replacement for a day shift left empty when an RN did not show up to replace LPN-B, and stated NA-A asked if TMA-A could give R3 his medications. TMA-A stated she told NA-A "technically, I cannot because they are

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given through a tube," but said NA-A replied, "but you know how," and "it's the only way he will get them." TMA-A stated she then gave R3 his medications via his G-tube, knowing she was not licensed, but out of concern for R3. TMA-A then stated she started checking the BG levels of diabetics, and then did administer insulin as she was concerned for the residents. TMA-A also stated she did her best to maintain the patency of R3's tracheostomy, urging him to cough out secretions to keep the airway open. TMA-A stated if his airway had come blocked she would have had to suction his airway which was a nursing function. TMA-A stated she was unsure what they were to do since there was not a nurse in the building.

TMA-A stated LPN-A had come to the building around 10 or 10:30 a.m. but had not punched in for work. TMA-A stated she understood LPN-A had a personal appointment, and things to do at home and was not available to work a full shift. TMA-A stated she understood LPN-A would have had to stay until 6:00 p.m. until RN-B returned to the facility and would have had to miss her own personal commitments. TMA-A stated she understood that a nurse was always to wait for their replacement or it was considered "patient abandonment" and the nurse might lose their license for that. TMA-A said she understood from NA-A that the RDOP had been notified. TMA-A started to cry and said she understood LPN-B had remained "punched in" on the time clock so it looked like a nurse was on duty, but TMA-A stated there was no nurse to take care of the residents, and further stated, "It was a terrible situation that day; I was so nervous and so scared. I just kept saying this isn ' t right, we shouldn ' t have to do this [work without a nurse]."

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According to an interview on 11/3/2, 11:31 a.m. the medical director (MD)-A stated, per his contract, he was supposed to be in the building at least monthly to attend the facility quality assessment and performance improvement meetings but this was spotty due to a turnover in administrative leadership in the building. MD-A stated he thought he had last been in the building sometime in September. MD-A stated he had not been notified that the facility had not had a nurse on duty for some hours on 10/14/22. MD-A stated he had many concerns upon learning that information as the facility had a number of residents with high medical acuity. MD-A stated R3 came to mind as someone who was "quite ill" and could not "be an advocate for himself." MD-A stated leaving R3 without a nurse on duty was "a major error." MD-A stated a concern with an unlicensed person giving insulin without being licensed even if that person had given insulin in the past. MD-A stated, "regardless of experience, they are unlicensed and that should not have occurred." MD-A stated his specific concerns related to insulin were "the accuracy of the insulin dose being provided. Are they giving the correct amount? Insulin can be quite dangerous if given inappropriately." MD-A also stated a nurse sleeping nearby was not to be counted as nursing coverage as sleeping could not be construed as "being on duty" and if there was an emergency it would still take time for staff to go to that area, wake the person and bring them back to the facility.

A request was made for the facility nursing schedule for October of 2022 including any changes made since it was posted. A review of the week of 10/9/22 through 10/15/22 was done

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and revealed the following:
-the facility scheduler had written at the top of the page, "*no open shifts"
-RN-C was not listed as scheduled to work on 10/14/22
-LPN-B was listed as picking up a shift from 6 p.m. on 10/13/22 through 6:15 a.m. on 10/14/22
-LPN-B was also listed as scheduled to work 6:15 a.m. on 10/14/22 through 2 p.m. (this would have been a 20 hour shift)
-LPN-B was scheduled to return to work six hours after the 20 hour shift, to work an additional eight hour shift starting at 8 p.m. This was to provide direct care as a "nursing assistant."
-RN-B was listed as working a "nursing assistant" shift from 10 p.m. on 10/13/22 through 6:15 a.m.
-RN-B was listed as scheduled to work an RN shift from 2:15 p.m until 10 p.m. on 10/14/22, and then continue working until 4:15 a.m. as a "nursing assistant."

Further review of the facility schedule revealed TMA-A was not listed as scheduled to work as a TMA or nursing assistant on 10/14/22. LPN-A was also not listed on the schedule for 10/14/22.

A request was made for the handwritten time-sheet records of LPN-B. The facility provided a form titled Pine View Rehabilitation & Senior Living Time sheet adjustment request. The form indicated, "please adjust the time sheet for the date indicated (please put actual times worked, not scheduled times.)" The scheduled shift indicated LPN-B worked 10/13/22 from 6 p.m. until 6 a.m. The 6 a.m. was crossed off and 8 a.m. was written in as a correction and the reason listed was "short staff." The time-sheet adjustment was signed by LPN-B on 10/13/22 and co-signed by RN-B on 10/14/22.

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A request was made for the handwritten time-sheet records of RN-B. The facility provided a form with the title of a different facility at the top; however, RN-B had written "Pineview" on the form dated 10/13/22. The 10/13/22 form indicated RN-B worked from 9:30 p.m. on 10/13/22 and signed out at 6:00 a.m. The form was signed by RN-B with no supervisor's signature. The time-sheet for 10/14/22 indicated RN-B started working at 2:00 p.m. and took a break from 7:00 p.m. and then worked from 8:00 p.m. until 4:15 a.m. This was also signed by RN-B, but not by a supervisor.

A request was made for a print out of the digital time-clock record of hours worked. This record indicated the facility paid LPN-B for hours worked from 6:00 p.m. until 6:00 a.m. on 10/13/22, and from 6:00 a.m. through 2:00 p.m. on 10/14/22 and then from 7 p.m. on 10/14/22 until 7 a.m. on 10/15/22. The digital print out of the time-clock record indicated RN-B was paid from 9:30 p.m. on 10/13/22 until 6:00 a.m. on 10/14/22, and then again on 10/14/22 from 2:00 p.m. until 4:15 a.m. on 10/15/22.

A request was made for a time-stamped record of medication administration times for R2 on 10/14/22. This record indicated RN-B had signed R2's Novolog (rapid acting insulin) Flexpen, 2 units for the morning medication pass at 4:13 p.m. This record also indicated RN-B signed the same medication and same amount for the noon med pass, but also signed this at 4:13 p.m. The record also indicated RN-B documented R2's Basaglar (slow acting insulin) Kwik Pen, 30 units, for the morning medication pass at 4:10 p.m. RN-B also documented having given 25 units of

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F 725	Continued From page 16 the Basaglar in the afternoon, documenting this as having been given at 5:31 p.m. A request was made for the time-stamped record of medication administration times for R3, R4, R5, and R7 on 10/14/22, but these were not provided. The Facility Assessment Tool, not signed or dated, indicated the facility had three 8 hour shifts per day, and for all shifts, "there is an LPN or an RN on the floor." An additional 40 page document titled, "staffing standards for Pine View Rehabilitation & Senior living" was provided. This document indicated it was compiled in 2008 by the University Of California and consisted of "nursing home staffing standards in state statutes and regulations." The document further indicated it was based on a facility with 100 beds. The document indicated the expectation for the state of Minnesota was "sufficient numbers & adequate to the needs." The document did not address the federal regulations for skilled nursing facilities under a skilled facilities certification by the Centers of Medicare and Medicaid.	F 725		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		12/9/22

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PINE VIEW REHABILITATION AND SENIOR LIVING	425 NORTH BADGER STREET CALEDONIA, MN 55921

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F 842	Continued From page 17	F 842		

to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 18 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an accurate medication administration record (MAR) for 4 of residents (R2,R4, R5,R7) reviewed for insulin administration and failed to maintain an accurate MAR and treatment administration record (TAR) for 1 of 1 residents (R3) receiving medications, a tube feeding and fluids through a gastrostomy tube as well as requiring treatments to maintain a rectal tube, a Foley catheter and range of motion. Findings include: According to R2's annual Minimum Data Set (MDS) dated 8/19/22, R2 was cognitively intact; marked as medically complex with diagnosis of traumatic brain injury, paraplegia and diabetes mellitus among other co-morbidities. According to R3's quarterly MDS dated 9/2/22,	F 842	The Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facilities credible allegation of compliance. Based on interview and record review, the facility failed to maintain an accurate medication administration record (MAR) for 4 of residents (R2,R4, R5,R7) reviewed for insulin administration and failed to maintain an accurate MAR and treatment administration record (TAR) for 1 of 1 residents (R3) receiving	

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Continued From page 19

R3 was unable to respond to any cognitive assessment and staff indicated R3 was severely impaired. R3 had a primary diagnosis of traumatic brain dysfunction, quadriplegia, traumatic brain injury, a seizure disorder and had a tracheotomy (surgically created opening into the trachea for persons who have difficulty breathing or maintaining oxygen levels through the mouth/nose). MDS also indicated R3 had a G-tube and required tube feedings.

According to R4's quarterly MDS dated 9/9/22, R4 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as being cognitively intact in January of 2022). R4 was marked as medically complex with a diagnosis of diabetes mellitus, malnutrition, a history of a stroke and other comorbidities.

According to R5's quarterly MDS dated 8/20/22, R5 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as moderately cognitively impaired 12/7/21). R5 was marked as medically complex with a diagnosis of diabetes mellitus, cerebral palsy and hemiplegia, along with other diagnosis. R5 also had renal disease and required dialysis.

According to R7's five day MDS dated 10/10/22, R7 was marked as medically complex with a diagnoses of diabetes mellitus, heart failure, malnutrition, chronic respiratory disorder, along with other diagnosis. R7 also had renal disease and required dialysis.

According to physician orders in their medical records, R2, R4, R5 and R7 all required daily injections of insulin to control their blood sugar. R3 required medications be given through a

F 842

medications, a tube feeding and fluids through a gastrostomy tube as well as requiring treatments to maintain a rectal tube, a Foley catheter and range of motion.

2 The facility has determined that all residents have the potential to be affected by the deficient practice.

3.R2, R4, R5 and R7, all were marked as having had insulin administered by a registered nurse (RN)-B during the morning medication pass, around breakfast time in the facility on 10/14/22, although time-sheet records indicated RN-B was not working at that time.
Rn B was Inserviced on the correct documentation of medications and following doctors orders to administer meds on time, and to only document the medications after she has gave them.
R3's October 2022 MAR and TAR did not show that R3 received his medication or treatments, the medication and treatments on 10/14/22 were not signed off as being completed: education was done with the nursing staff on documentation of medication after given, education included proper time, route, following the exact doctors orders, and to notify the physician for any med not given.

The Facility Assessment Tool, was updated to indicate the facility has a plan in place to train staff in the provisions of various skilled nursing cares; however, the tool includes the expectation for

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F 842	Continued From page 20 G-tube, as well as supplemental fluids of 300 ml four times daily via the G-tube. R3 had orders for constantly humidified oxygen to be supplied through his tracheostomy tube. R3 also had orders to irrigate his Foley catheter if it should become obstructed, and orders to irrigate his rectal tube every four hours and as needed to maintain patency of the tube (R3 required the rectal tube due to having an open sacral wound and a history of infection of the wounds with resulting sepsis) R3 was receiving a tube feeding via his G-tube, and the feeding was to be discontinued by the nursing during the morning shift. According to the October 2022 MAR for R2, R4, R5 and R7, all were marked as having had insulin administered by a registered nurse (RN)-B during the morning medication pass, around breakfast time in the facility on 10/14/22, although time-sheet records indicated RN-B was not working at that time. R3's October 2022 MAR and TAR did not show that R3 received the following medication or treatments on 10/14/22, as they were not signed off: Lactobacillus , one tab of 50 million units via G-tube (for GI health); hydrochlorothiazide 25 mg per G-tube (for blood pressure and fluid retention); MiraLAX powder 17 Gm per G-tube (prevent constipation); multivitamin and minerals 30 ml per G-tube (for skin healing); Tylenol 650 mg per G-tube before providing dressing change (pain control); Apixiban 5 mg per G-tube (prevent embolism/blood clots); vitamin 5 500 mg per G-tube (supplement); Keppra solution 7.5 ml of a 100 mg/ml solution per G-tube (seizure prevention); metoprolol tartrate 50 mg per G-tube (for blood pressure); Proheal liquid 30 ml per G-tube (protein for healing); artificial tears two	F 842	documentation, and the competency for nursing staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 5. The Director of nursing and administrator will visually monitor med pass 3 times weekly times 4 weeks to ensure all medications are given on time and documented as given is reflecting in the mar and tar, they will also pull med pass administration progress reports in the point click care module to monitor and measure the progress of the nursing staff sand if they are being compliant with the MD orders, if there is any exception then the Don will be notified and can follow up on the reasons why . the progress of each med pass reviewed and the results of their daily and weekly reviews will be presented to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or subsequent plan of correction if modifications are needed. action will be completed 12/09/22	

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F 842	Continued From page 21 drops each eye (dry eyes); ipratropium-albuterol solution 3 ml to have been given via nebulizer at 9:00 a.m. and again at 1:00 p.m. and including a pulse, and assessment of lung status. R3's MAR indicated R3 was to have received a 30 ml fluid flush of his G-tube at 9:00 a.m. and 1:00 p.m. but this was not documented as having been done, nor was a fluid bolus of 300 ml ordered for those times. According to R3's TAR, RN-B documented having completed R3's vital signs for the day shift. No person documented having stopped R3's tube feeding at 9:00 a.m. as ordered, or performing G-tube care or perform passive range of motion to ankles and hips, nor were ordered contracture boots signed as having been placed on R3 on 10/14/22. R3's TAR did not contain documentation that a nurse had performed tracheostomy cares, or provided the ordered sodium chloride solution per his tracheostomy to help thin secretions. No signature was found indicating R3 had been receiving oxygen, or what his blood oxygen saturation was, nor was their indication that the cuff on his trach had been checked to ensure a tight seal for adequate oxygenation. The TAR did not indicate a nurse had applied R3's "vest therapy" which is a vibrating appliance that helps to loosen respiratory secretions. According to an interview on 11/2/22, 9:54 a.m. and a follow up interview on 11/3/22, 10:15 a.m. a nursing assistant (NA)-A stated she did the scheduling for the nursing department. On 10/13/22 NA-A stated she was called at home by one of the night shift nurses, RN-B at 6:14 a.m. to notify her that the relief nurse, RN-C had not shown up for his scheduled shift. NA-A reported she was aware RN-B later left the facility, but NA-A was not sure at what time. NA-A had called	F 842		

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another nurse, LPN-A and understood that she would come to work later in the morning around 10 a.m.. During the interview on 11/2/22, NA-A first stated LPN-B worked until LPN-A arrived, but later stated LPN-B had finished providing wound care to R3 and then went "upstairs to sleep" (there is an attached building with sleeping rooms where some staff stay). NA-A stated LPN-B did not "punch out" and was listed on the schedule as working 6:15 a.m. until 2 p.m. because "LPN-A did not end up picking up the shift". NA-A stated LPN-A came to the building, but did not punch in, and left without working. NA-A stated there was not a nurse on-duty after LPN-B left the building until RN-B returned at around 2:00 p.m.

According to an interview on 11/2/22, 10:25 a.m. TMA-B stated she was scheduled to work on 10/14/22, starting at 6:00 a.m. TMA-A did not know when LPN-B left the facility, but stated she did not see her or any other nurse working from about 8 a.m. until the end of the shift at about 2:00 p.m. TMA-B stated TMA-A was in the building and came to assist with checking diabetic blood glucose (BG) levels/blood sugars. TMA-B said she thought TMA-A also gave insulin injections.

According to an interview on 11/2/22, 10:49 a.m. LPN-A stated she had received a call in the early morning about the open shift on 10/14/22, and came to the building later where she found TMA-A struggling with the administration of an insulin dose. LPN-A stated she had not punched in to work, but assisted TMA-A with the insulin flex pen (a syringe that holds an insulin vial and is used multiple times for dosing insulin) and then left the building. LPN-A stated she had not provided any cares or given medications on

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10/14/22.

According to an interview on 11/2/22, 11:31 a.m. the business office manager (BOM) reviewed LPN-B's computerized time sheet which indicated she had documented hours of work starting on 10/13/22 at 6 p.m. through 6 a.m. on 10/14/22 and then documented hours of work starting at 6:15 a.m. on 10/14/22 through 2:00 p.m. BOM then recalled that LPN-B was a new employee and had probably been writing her hours worked on a time sheet form rather than punching the time clock. BOM located the hand written, signed document that indicated LPN-B had worked from 10/13/22, 6 p.m. through 10/14/22, 8:00 a.m. The record indicated LPN-B was scheduled to work until 6:00 a.m. on 10/14/22, but had stayed an additional two hours. BOM was unable to say why the computer hours did not match the written/signed document from LPN-B.

According to an interview on 11/02/22, 11:38 a.m. the DON stated she works in the building Monday through Friday and works remotely on Fridays; however, staff should call her with any nursing concerns they are unable to handle. DON stated she was not available after about 8:15 a.m. on 10/14/22 as she had a personal emergency, but said she had received a call earlier at about 6:27 a.m. from NA-A regarding RN-C not showing up for his scheduled shift, but DON was unable to recall anymore from that day.

According to an interview on 11/2/22, 12:58 p.m. LPN-B stated she was aware, on 10/14/22, that the RN scheduled to replace her in the morning had not shown up for work. LPN-B stated she "stayed a little late to finish charting" on that day. LPN-B stated she had "attended to the needs of

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F 842	Continued From page 24 the patients", but would not confirm if she had given any resident their insulin dose, and stated she did not know why the insulin doses were signed off as having been given by a different nurse. LPN-B stated she was not using the time-clock at that time as she was quite new, and instead was "signing in and signing out on a time slip [paper]." LPN-B denied knowing the computerized record showed she was working from 6:15 a.m. to 2 p.m. on 10/14/22, and further stated she was not paid when in the sleeping quarters, saying, "when I'm off, I'm off." According to an interview on 11/2/22, 2:25 p.m. RN-B stated she had been working the overnight shift with LPN-B from 10/13/22 until the morning of 10/14/22. RN-B stated she had been filling the nursing assistant shift. RN-B stated she had been aware that the relief nurse did not show up for his shift on the morning of 10/14/22, but stated she left the building in the morning, thinking it was about 6 a.m. RN-B stated she had returned to the building later to work a 2 p.m. to 6 p.m. shift, but stated she was not sure when she had entered the building. RN-B stated she did not have access to the time-clock so wrote out her times worked on a paper form that she signed. RN-B stated she had not been in the building when the morning insulin was to be given and could not recall why she had signed off the insulin doses to R2,R4, R5 and R7. RN-B further stated she could not recall why her initials were showing on R3's electronic MAR indicating she had been the one to give his morning medications via G-tube on 10/14/22. RN-B stated she had not given any morning medication and had not done any treatments that morning. RN-B stated she could recall that there were a lot of medications showing up in red, meaning they had been	F 842		

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F 842	Continued From page 25 missed or were late, and if she had signed them, she "signed in error." According to an interview on 11/2/22, 2:41 p.m. DON stated she recalled a conversation she had had with NA-A on 10/14/22 regarding staffing concerns. She recalled being told there were two TMAs on the schedule, TMA-A and TMA-B. DON stated TMA-A used to be a nurse, but was not any longer. DON stated a TMA was not able to give insulin or do any treatments such as wound care and had never been informed that this had occurred. According to an interview on 11/3/22, 9:29 a.m. TMA-A stated she worked in the facility in the laundry, worked as a nursing assistant and also as a TMA. TMA-A stated NA-A told her she was unable to locate a replacement for a day shift left empty on 10/14/22 when an RN did not show up to replace LPN-B. TMA-A stated NA-A asked if TMA-A could give R3 his medications, and TMA-A stated she did give this even though she was not licensed to do so. TMA-A stated she then started checking the BG levels of diabetics, and administered insulin to the diabetics in the facility (R2,R4, R5,R7). TMA-A stated she was able to access the resident orders and TMA-B had opened the medication room so she was able to get to resident medications. A request was made for the facility nursing schedule for October of 2022, including any changes that had been made to the schedule since it was originally posted, and any open shifts. For the week of 10/9/22 through 10/15/22, LPN-B was listed on the schedule as working from 6:15 a.m. of 10/14/22 until 2:00 p.m. RN-B was listed as working a nursing assistant shift	F 842		

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from 10:00 p.m. on 10/13/22 through 6:15 a.m. On 10/14/22. RN-B was not listed as working during the day shift between 6 a.m. and 2 p.m. but was listed as scheduled to work an RN shift from 2:15 p.m. until 10:00 p.m.

A request was made for the handwritten time-sheet records of RN-B. The facility provided a form with the title of a different facility at the top; however, RN-B had written "Pineview" on the form dated 10/13/22. The 10/13/22 form indicated RN-B worked from 9:30 p.m. on 10/13/22 and signed out at 6:00 a.m. The form was signed by RN-B with no supervisor's signature. The time-sheet for 10/14/22 indicated RN-B started working at 2:00 p.m. and took a break from 7:00 p.m. and then worked from 8:00 p.m. until 4:15 p.m. This was also signed by RN-B, but not by a supervisor.

A request was made for a print out of the digital time-clock record of hours worked. This record indicated the facility paid RN-B from 9:30 p.m. on 10/13/22 until 6:00 a.m. on 10/14/22, and then again on 10/14/22 from 2:00 p.m. until 4:15 a.m. on 10/15/22.

A request was made for a time-stamped record of medication administration times for R2 on 10/14/22. This record indicated RN-B had signed R2's Novolog (rapid acting insulin) FlexPen, 2 units for the morning medication pass at 4:13 p.m. This record also indicated RN-B signed the same medication and same amount for the noon med pass, but also signed this at 4:13 p.m. The record also indicated RN-B documented R2's Basaglar (slow acting insulin) Kwik Pen, 30 units, for the morning medication pass at 4:10 p.m. RN-B also documented having given 25 units of

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PINE VIEW REHABILITATION AND SENIOR LIVING	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 842	Continued From page 27	F 842		

the Basaglar in the afternoon, documenting this as having been given at 5:31 p.m.

A request was made for the time-stamped record of medication administration times for R3, R4, R5, and R7 on 10/14/22, but these were not provided.

The Facility Assessment Tool, not signed or dated, indicated the facility had a plan in place to train staff in the provisions of various skilled nursing cares; however, the tool did not describe expectation for documentation, or list this as a competency for nursing staff.

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	00073	A. BUILDING: ______ B. WING ______	C 11/03/2022

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PINE VIEW REHABILITATION AND SENIOR LIV	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

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2 000	Initial Comments	2 000		

*****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 11/2/22 and 11/3/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00073	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 11/03/2022

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54995219C (MN86790), with a licensing order issues at STAG 0820 and a related licensing order issued at STAG 0625. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described	2 625		11/30/22

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2 625	Continued From page 3	2 625		

in part 4658.0810;
I. reports of laboratory examinations;
J. dates and times of all treatments and dressings;
K. dates and times of visits by all licensed health care practitioners;
L. visits to clinics or hospitals;
M. any orders or instructions relative to the comprehensive plan of care;
N. any change in the resident's sleeping habits or appetite;
O. pertinent factors regarding changes in the resident's general conditions; and
P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the facility failed to maintain an accurate medication administration record (MAR) for 4 of residents (R2,R4, R5,R7) reviewed for insulin administration and failed to maintain an accurate MAR and treatment administration record (TAR) for 1 of 1 residents (R3) receiving medications, a tube feeding and fluids through a gastrostomy tube as well as requiring treatments to maintain a rectal tube, a Foley catheter and range of motion.

no poc due

Findings include:

According to R2's annual Minimum Data Set (MDS) dated 8/19/22, R2 was cognitively intact; marked as medically complex with diagnosis of traumatic brain injury, paraplegia and diabetes mellitus among other co-morbidities.

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2 625	Continued From page 4	2 625		

According to R3's quarterly MDS dated 9/2/22, R3 was unable to respond to any cognitive assessment and staff indicated R3 was severely impaired. R3 had a primary diagnosis of traumatic brain dysfunction, quadriplegia, traumatic brain injury, a seizure disorder and had a tracheotomy (surgically created opening into the trachea for persons who have difficulty breathing or maintaining oxygen levels through the mouth/nose). MDS also indicated R3 had a G-tube and required tube feedings.

According to R4's quarterly MDS dated 9/9/22, R4 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as being cognitively intact in January of 2022). R4 was marked as medically complex with a diagnosis of diabetes mellitus, malnutrition, a history of a stroke and other comorbidities.

According to R5's quarterly MDS dated 8/20/22, R5 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as moderately cognitively impaired 12/7/21). R5 was marked as medically complex with a diagnosis of diabetes mellitus, cerebral palsy and hemiplegia, along with other diagnosis. R5 also had renal disease and required dialysis.

According to R7's five day MDS dated 10/10/22, R7 was marked as medically complex with a diagnoses of diabetes mellitus, heart failure, malnutrition, chronic respiratory disorder, along with other diagnosis. R7 also had renal disease and required dialysis.

According to physician orders in their medical records, R2, R4, R5 and R7 all required daily injections of insulin to control their blood sugar.

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2 625	Continued From page 5 R3 required medications be given through a G-tube, as well as supplemental fluids of 300 ml four times daily via the G-tube. R3 had orders for constantly humidified oxygen to be supplied through his tracheostomy tube. R3 also had orders to irrigate his Foley catheter if it should become obstructed, and orders to irrigate his rectal tube every four hours and as needed to maintain patency of the tube (R3 required the rectal tube due to having an open sacral wound and a history of infection of the wounds with resulting sepsis) R3 was receiving a tube feeding via his G-tube, and the feeding was to be discontinued by the nursing during the morning shift. According to the October 2022 MAR for R2, R4, R5 and R7, all were marked as having had insulin administered by a registered nurse (RN)-B during the morning medication pass, around breakfast time in the facility on 10/14/22, although time-sheet records indicated RN-B was not working at that time. R3's October 2022 MAR and TAR did not show that R3 received the following medication or treatments on 10/14/22, as they were not signed off: Lactobacillus , one tab of 50 million units via G-tube (for GI health); hydrochlorothiazide 25 mg per G-tube (for blood pressure and fluid retention); MiraLAX powder 17 Gm per G-tube (prevent constipation); multivitamin and minerals 30 ml per G-tube (for skin healing); Tylenol 650 mg per G-tube before providing dressing change (pain control); Apixiban 5 mg per G-tube (prevent embolism/blood clots); vitamin 5 500 mg per G-tube (supplement); Keppra solution 7.5 ml of a 100 mg/ml solution per G-tube (seizure prevention); metoprolol tartrate 50 mg per G-tube (for blood pressure); Proheal liquid 30 ml per G-tube (protein for healing); artificial tears two	2 625		

Minnesota Department of Health

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2 625	Continued From page 6 drops each eye (dry eyes); ipratropium-albuterol solution 3 ml to have been given via nebulizer at 9:00 a.m. and again at 1:00 p.m. and including a pulse, and assessment of lung status. R3's MAR indicated R3 was to have received a 30 ml fluid flush of his G-tube at 9:00 a.m. and 1:00 p.m. but this was not documented as having been done, nor was a fluid bolus of 300 ml ordered for those times. According to R3's TAR, RN-B documented having completed R3's vital signs for the day shift. No person documented having stopped R3's tube feeding at 9:00 a.m. as ordered, or performing G-tube care or perform passive range of motion to ankles and hips, nor were ordered contracture boots signed as having been placed on R3 on 10/14/22. R3's TAR did not contain documentation that a nurse had performed tracheostomy cares, or provided the ordered sodium chloride solution per his tracheostomy to help thin secretions. No signature was found indicating R3 had been receiving oxygen, or what his blood oxygen saturation was, nor was their indication that the cuff on his trach had been checked to ensure a tight seal for adequate oxygenation. The TAR did not indicate a nurse had applied R3's "vest therapy" which is a vibrating appliance that helps to loosen respiratory secretions. According to an interview on 11/2/22, 9:54 a.m. and a follow up interview on 11/3/22, 10:15 a.m. a nursing assistant (NA)-A stated she did the scheduling for the nursing department. On 10/13/22 NA-A stated she was called at home by one of the night shift nurses, RN-B at 6:14 a.m. to notify her that the relief nurse, RN-C had not shown up for his scheduled shift. NA-A reported she was aware RN-B later left the facility, but NA-A was not sure at what time. NA-A had called another nurse, LPN-A and understood that she	2 625		

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2 625	Continued From page 7	2 625		

would come to work later in the morning around 10 a.m.. During the interview on 11/2/22, NA-A first stated LPN-B worked until LPN-A arrived, but later stated LPN-B had finished providing wound care to R3 and then went "upstairs to sleep" (there is an attached building with sleeping rooms where some staff stay). NA-A stated LPN-B did not "punch out" and was listed on the schedule as working 6:15 a.m. until 2 p.m. because "LPN-A did not end up picking up the shift". NA-A stated LPN-A came to the building, but did not punch in, and left without working. NA-A stated there was not a nurse on-duty after LPN-B left the building until RN-B returned at around 2:00 p.m.

According to an interview on 11/2/22, 10:25 a.m. TMA-B stated she was scheduled to work on 10/14/22, starting at 6:00 a.m. TMA-A did not know when LPN-B left the facility, but stated she did not see her or any other nurse working from about 8 a.m. until the end of the shift at about 2:00 p.m. TMA-B stated TMA-A was in the building and came to assist with checking diabetic blood glucose (BG) levels/blood sugars. TMA-B said she thought TMA-A also gave insulin injections.

According to an interview on 11/2/22, 10:49 a.m. LPN-A stated she had received a call in the early morning about the open shift on 10/14/22, and came to the building later where she found TMA-A struggling with the administration of an insulin dose. LPN-A stated she had not punched in to work, but assisted TMA-A with the insulin flex pen (a syringe that holds an insulin vial and is used multiple times for dosing insulin) and then left the building. LPN-A stated she had not provided any cares or given medications on 10/14/22.

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2 625	Continued From page 8 According to an interview on 11/2/22, 11:31 a.m. the business office manager (BOM) reviewed LPN-B's computerized time sheet which indicated she had documented hours of work starting on 10/13/22 at 6 p.m. through 6 a.m. on 10/14/22 and then documented hours of work starting at 6:15 a.m. on 10/14/22 through 2:00 p.m. BOM then recalled that LPN-B was a new employee and had probably been writing her hours worked on a time sheet form rather than punching the time clock. BOM located the hand written, signed document that indicated LPN-B had worked from 10/13/22, 6 p.m. through 10/14/22, 8:00 a.m. The record indicated LPN-B was scheduled to work until 6:00 a.m. on 10/14/22, but had stayed an additional two hours. BOM was unable to say why the computer hours did not match the written/signed document from LPN-B. According to an interview on 11/02/22, 11:38 a.m. the DON stated she works in the building Monday through Friday and works remotely on Fridays; however, staff should call her with any nursing concerns they are unable to handle. DON stated she was not available after about 8:15 a.m. on 10/14/22 as she had a personal emergency, but said she had received a call earlier at about 6:27 a.m. from NA-A regarding RN-C not showing up for his scheduled shift, but DON was unable to recall anymore from that day. According to an interview on 11/2/22, 12:58 p.m. LPN-B stated she was aware, on 10/14/22, that the RN scheduled to replace her in the morning had not shown up for work. LPN-B stated she "stayed a little late to finish charting" on that day. LPN-B stated she had "attended to the needs of the patients", but would not confirm if she had given any resident their insulin dose, and stated she did not know why the insulin doses were	2 625		

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2 625	Continued From page 9	2 625		

signed off as having been given by a different nurse. LPN-B stated she was not using the time-clock at that time as she was quite new, and instead was "signing in and signing out on a time slip [paper]." LPN-B denied knowing the computerized record showed she was working from 6:15 a.m. to 2 p.m. on 10/14/22, and further stated she was not paid when in the sleeping quarters, saying, "when I'm off, I'm off."

According to an interview on 11/2/22, 2:25 p.m. RN-B stated she had been working the overnight shift with LPN-B from 10/13/22 until the morning of 10/14/22. RN-B stated she had been filling the nursing assistant shift. RN-B stated she had been aware that the relief nurse did not show up for his shift on the morning of 10/14/22, but stated she left the building in the morning, thinking it was about 6 a.m. RN-B stated she had returned to the building later to work a 2 p.m. to 6 p.m. shift, but stated she was not sure when she had entered the building. RN-B stated she did not have access to the time-clock so wrote out her times worked on a paper form that she signed. RN-B stated she had not been in the building when the morning insulin was to be given and could not recall why she had signed off the insulin doses to R2,R4, R5 and R7. RN-B further stated she could not recall why her initials were showing on R3's electronic MAR indicating she had been the one to give his morning medications via G-tube on 10/14/22. RN-B stated she had not given any morning medication and had not done any treatments that morning. RN-B stated she could recall that there were a lot of medications showing up in red, meaning they had been missed or were late, and if she had signed them, she "signed in error."

According to an interview on 11/2/22, 2:41 p.m.

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2 625	Continued From page 10	2 625		

DON stated she recalled a conversation she had had with NA-A on 10/14/22 regarding staffing concerns. She recalled being told there were two TMAs on the schedule, TMA-A and TMA-B. DON stated TMA-A used to be a nurse, but was not any longer. DON stated a TMA was not able to give insulin or do any treatments such as wound care and had never been informed that this had occurred.

According to an interview on 11/3/22, 9:29 a.m. TMA-A stated she worked in the facility in the laundry, worked as a nursing assistant and also as a TMA. TMA-A stated NA-A told her she was unable to locate a replacement for a day shift left empty on 10/14/22 when an RN did not show up to replace LPN-B. TMA-A stated NA-A asked if TMA-A could give R3 his medications, and TMA-A stated she did give this even though she was not licensed to do so. TMA-A stated she then started checking the BG levels of diabetics, and administered insulin to the diabetics in the facility (R2,R4, R5,R7). TMA-A stated she was able to access the resident orders and TMA-B had opened the medication room so she was able to get to resident medications.

A request was made for the facility nursing schedule for October of 2022, including any changes that had been made to the schedule since it was originally posted, and any open shifts. For the week of 10/9/22 through 10/15/22, LPN-B was listed on the schedule as working from 6:15 a.m. of 10/14/22 until 2:00 p.m. RN-B was listed as working a nursing assistant shift from 10:00 p.m. on 10/13/22 through 6:15 a.m. On 10/14/22. RN-B was not listed as working during the day shift between 6 a.m. and 2 p.m. but was listed as scheduled to work an RN shift from 2:15 p.m. until 10:00 p.m.

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A request was made for the handwritten time-sheet records of RN-B. The facility provided a form with the title of a different facility at the top; however, RN-B had written "Pineview" on the form dated 10/13/22. The 10/13/22 form indicated RN-B worked from 9:30 p.m. on 10/13/22 and signed out at 6:00 a.m. The form was signed by RN-B with no supervisor's signature. The time-sheet for 10/14/22 indicated RN-B started working at 2:00 p.m. and took a break from 7:00 p.m. and then worked from 8:00 p.m. until 4:15 p.m. This was also signed by RN-B, but not by a supervisor.

A request was made for a print out of the digital time-clock record of hours worked. This record indicated the facility paid RN-B from 9:30 p.m. on 10/13/22 until 6:00 a.m. on 10/14/22, and then again on 10/14/22 from 2:00 p.m. until 4:15 a.m. on 10/15/22.

A request was made for a time-stamped record of medication administration times for R2 on 10/14/22. This record indicated RN-B had signed R2's Novolog (rapid acting insulin) FlexPen, 2 units for the morning medication pass at 4:13 p.m. This record also indicated RN-B signed the same medication and same amount for the noon med pass, but also signed this at 4:13 p.m. The record also indicated RN-B documented R2's Basaglar (slow acting insulin) Kwik Pen, 30 units, for the morning medication pass at 4:10 p.m. RN-B also documented having given 25 units of the Basaglar in the afternoon, documenting this as having been given at 5:31 p.m.

A request was made for the time-stamped record of medication administration times for R3, R4, R5, and R7 on 10/14/22, but these were not

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PINE VIEW REHABILITATION AND SENIOR LIV	425 NORTH BADGER STREET CALEDONIA, MN 55921

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2 625	Continued From page 12 provided. The Facility Assessment Tool, not signed or dated, indicated the facility had a plan in place to train staff in the provisions of various skilled nursing cares; however, the tool did not describe expectation for documentation, or list this as a competency for nursing staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could provide education to nursing staff on proper documentation of resident medication administration and treatments provided so a resident's record accurately shows who provided medications and/or cares, or if a medication or treatment was not provided, the record indicates a reason. DON or designee could do audits of records to ensure resident medications and/or cares were documented at the time period they were provided, and by the person providing the cares. If a medication or care was not documented as having been provided, DON or designee could follow-up with the scheduled nursing staff. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 625		
2 820	MN Rule 4658.0510 Subp. 5 Nursing Personnel; Assignment of duties Subp. 5. Assignment of duties. Nursing personnel must not perform duties for which they have not had proper and sufficient training.	2 820		11/30/22

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Duties assigned to nursing personnel must be consistent with their training, experience, competence, and credentialing.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure a licensed practical nurse or a registered nurse was in the facility at all times to provide skilled nursing cares, daily assessments of resident needs or supervise the work of unlicensed personnel. It was discovered that an unlicensed person administered insulin to 4 of 4 residents (R2,R4, R5,R7), administered crushed medications through a gastrostomy tube (G-tube) to 1 of 1 residents (R3) and monitored the status of 1 of 1 residents (R3) who had a tracheostomy(surgically created opening into the trachea for persons who have difficulty breathing or maintaining oxygen levels through the mouth/nose) and oxygen dependent.

no poc due

Findings include:

According to R2's annual Minimum Data Set (MDS) assessment dated 8/19/22, R2 was cognitively intact; marked as medically complex with diagnosis of traumatic brain injury, paraplegia and diabetes mellitus among other co-morbidities.

According to R3's quarterly MDS assessment dated 9/2/22, R3 was unable to respond to any cognitive assessment and staff indicated R3 was severely impaired. R3 had a primary diagnosis of traumatic brain dysfunction, quadriplegia, traumatic brain injury, a seizure disorder and had a tracheotomy. MDS also indicated R3 had a

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G-tube and required tube feedings.

According to R4's quarterly MDS assessment dated 9/9/22, R4 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as being cognitively intact in January of 2022). R4 was marked as medically complex with a diagnosis of diabetes mellitus, malnutrition, a history of a stroke and other comorbidities.

According to R5's quarterly MDS assessment dated 8/20/22, R5 was not assessed for cognitive ability, but staff indicated no change from baseline (last assessed as moderately cognitively impaired 12/7/21). R5 was marked as medically complex with a diagnosis of diabetes mellitus, cerebral palsy and hemiplegia, along with other diagnosis. R5 also had renal disease and required dialysis.

According to R7's five day MDS assessment dated 10/10/22, R7 was marked as medically complex with a diagnoses of diabetes mellitus, heart failure, malnutrition, chronic respiratory disorder, along with other diagnosis. R7 also had renal disease and required dialysis.

According to physician orders in their medical records, R2, R4, R5 and R7 all required daily injections of insulin to control their blood sugar. R3 required medications be given through a G-tube, as well as supplemental fluids of 300 ml(milliliters) four times daily via (by)G-tube. R3 had orders for constantly humidified oxygen to be supplied through his tracheostomy tube. R3 also had orders to irrigate his Foley catheter if it should become obstructed, and orders to irrigate his rectal tube every four hours and as needed to maintain patency of the tube (R3 required the

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2 820	Continued From page 15 rectal tube due to having an open sacral wound and a history of infection of the wounds with resulting sepsis). During an interview on 11/2/2022, at 9:27 a.m. registered nurse (RN)-A stated she was often called on her days off to work additional shifts. RN-A stated the facility had been struggling to have enough staff and stated, "it's getting to the point we are wondering, who will replace me at the end of my shift." RN-A stated she was aware there had been a day when the facility did not have a nurse in the building. During an interview on 11/2/22, at 9:54 a.m. and follow up interview on 11/3/22, 10:15 a.m. nursing assistant (NA)-A stated she did the scheduling for the nursing department. NA-A stated she usually comes to the facility at 7:00 a.m. on her scheduled work days, but on 10/14/22 was called at home by one of the night shift nurses, RN-B at 6:14 a.m. to notify her the relief nurse, RN-C had not shown up for his scheduled shift. NA-A then called RN-C, and got no answer, then called RN-A about covering the open shift but that call was not answered either. NA-A then called a licensed practical nurse (LPN)-A and left a message at 6:21 a.m. about the need for a nurse. At 6:25 a.m. NA-A called the director of nursing (DON) and left a voice mail concerning RN-C not showing up for work. NA-A then received a call from another night nurse, LPN-B, asking if someone was coming in to replace her. NA-A proceeded to the facility, and at 7:19 a.m. received a call from LPN-A stating she had things to do at home, but would come in sometime after 10 a.m. NA-A stated that RN-B left the facility on the morning of 10/14/22, but she was not sure at what time. NA-A then reported speaking to the DON for eight minutes, but could not recall	2 820		

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exactly what they had talked about.

During the interview on 11/2/22, NA-A first stated LPN-B worked until LPN-A arrived, but later stated LPN-B had finished providing wound care to R3 and then went "upstairs to sleep" (there is an attached building with sleeping rooms where some staff stay). NA-A stated LPN-B did not "punch out" and was listed on the schedule as working 6:15 a.m. until 2 p.m. because "LPN-A did not end up picking up the shift.". NA-A tried to reach the regional administrator at 8:46 a.m. and then again at 9:44 a.m. when they spoke for six minutes about NA-A's staffing concerns. At some time after that call, NA-A recalled that LPN-A did come to the building, but decided she was not going to work, and NA-A notified the regional administrator of the situation at 10:12 a.m. but she could not recall exactly what they talked about. NA-A stated there was a nursing assistant, trained medication aid (TMA)-B, who was able to pass oral medications, and later stated she understood TMA-A, who was not scheduled, had come up from her additional job in the laundry to assist. NA-A stated there was not a nurse on-duty after LPN-B left the building until RN-B returned at around 2:00 p.m.

According to an interview on 11/2/22, 10:25 a.m. TMA-B stated she was scheduled to work on 10/14/22, starting at 6:00 a.m. TMA-B stated, "I remember there wasn't anyone to do the nursing part and everyone was running around like what are we supposed to do? I got late starting on my pills because we were trying to figure out what to do." TMA-A did not know when LPN-B left the facility, but stated she did not see her or any other nurse working from about 8 a.m. until the end of the shift at about 2:00 p.m. when RN-B had returned to duty. TMA-B stated TMA-A was in the

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building and came to assist with checking morning diabetic blood glucose (BG) levels/blood sugars. TMA-B said she thought TMA-A also gave insulin injections. TMA-B did recall LPN-A coming to the building, but stated LPN-A did not punch in, was observed to be upset and crying and left soon after. TMA-A stated the DON was not in the building on Fridays, Saturdays and Sundays, and had heard staff were not to contact her. TMA-A said "I don't think anyone was in charge"[on 10/14/22].

According to an interview on 11/2/22, at 10:49 a.m. LPN-A stated she had received a call about the open shift on 10/14/22 in the morning, and had told NA-A that she had chores to do and could not come until after 10 a.m. but said she would work. LPN-A stated when she entered the facility TMA-A was in the dining area and said, "thank god, you're here." LPN-A did not see a nurse on duty and went to the social service office as the social service designee (SSD)-A was the only department head LPN-A could find. LPN-A reported the lack of a nurse on duty to SSD-A who told her to call the regional administrator. TMA-A then spoke to NA-A who told her, "I had the night nurse stay punched in when she went up to bed." LPN-A stated she got upset and told NA-A she was not going to stay as she was concerned there had not been a nurse on duty, and she needed to protect her license. LPN-A said she went to tell TMA-A that she was leaving, but found TMA-A struggling with an insulin flex pen (a syringe that holds an insulin vial and is used multiple times for dosing insulin). TMA-A reported she was giving insulin to R2, but 18 units of the dose would not inject, leaving R2 having received only a partial dose. LPN-A was able to intervene, changed the flex pen needle, primed the needle with 2 units and set the dose for the

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additional 18 units and gave the device back to TMA-A and then left the building. LPN-A stated when she had been called to work, she was not aware she would be the only nurse in the building and she had not been made aware that no nurse would be in the building until she arrived. LPN-A stated insulin should not be given by a TMA-A in a skilled nursing facility. LPN-A stated she did not know what would have happened if there had been an emergency in the building on 10/14/22, "I guess they would have to have called an ambulance."

According to an interview 11/2/22, at 11:12 a.m. SSD-A stated she recalled LPN-A had come to her office on 10/14/22 to tell her she had been called to come in to work, but had not realized she was going to be the only nurse, and did not want to stay. SSD-A stated the staffing coordinator was usually the person who would call the DON or an administrator if there were staffing issues or problems in the nursing department when they were out. SSD-A could not recall if any such contact was made on that day, but thought she recalled NA-A letting her know she had either LPN-B or RN-B returning to work the 6 a.m. to 2 p.m. portion of the open shift, and then RN-B was going to work 2:00 p.m. until 6 p.m.

According to an interview on 11/2/22, at 11:21 a.m. the regional director of operations (RDOP) stated she had received a call from the facility on 10/14/22 to notify her the scheduled nurse had not shown up for the day shift, but RDOP stated she thought there was an RN in the attached building sleeping. RDOP also said RN-B was in the building, but did not know at what time. RDOP stated the DON could be called at any time, but she was aware the DON had a personal issue to

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attend to on 10/14/22 and was not available. RDOP stated the facility could call her with any nursing concerns.

According to an interview on 11/2/22, at 11:31 a.m. the business office manager (BOM) stated an employee is not to stay "punched in" when they are sleeping. BOM reviewed LPN-B's computerized time sheet which indicated she had documented hours of work starting on 10/13/22 at 6 p.m. through 6 a.m. on 10/14/22 and then documented hours of work starting at 6:15 a.m. on 10/14/22 through 2:00 p.m. BOM then recalled that LPN-B was a new employee and had probably been writing her hours worked on a time sheet form rather than punching the time clock. BOM located the hand written, signed document that indicated LPN-B had worked from 10/13/22, 6 p.m. through 10/14/22, 8:00 a.m. The record indicated LPN-B was scheduled to work until 6:00 a.m. on 10/14/22, but had stayed an additional two hours. BOM was unable to say why the computer hours did not match the written/signed document from LPN-B.

According to an interview on 11/02/22, at 11:38 a.m. the DON stated she works in the building Monday through Thursday and works remotely on Fridays; however, staff should call her with any nursing concerns they are unable to handle. DON stated she was not available after about 8:15 a.m. on 10/14/22 as she had a personal emergency, but said she had received a call earlier at about 6:27 a.m. from NA-A regarding RN-C not showing up for his scheduled shift, but DON was unable to recall anymore from that day.

The facility DON stated she recently had shared the expected standards for nurse staffing with the facility's new administrator, and stated the ideal

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for the building was to have an RN charge nurse and an LPN, plus two TMAs to pass medications on a day shift. DON stated the minimum nurse staffing would be to have an RN and two TMAs. DON stated currently the facility did not have an RN designated on-call if there was not one in the building as they usually could contact her or someone from the corporate office.

The DON stated the facility provided sleeping quarters for some of the nurses, and depending on their contract, they were considered to be a facility resource who could be called upon at any time to come to the building "if they were available." DON stated if they had other commitments they were not required to come to the building to work if called. DON also stated the nurses were not to remain "punched in" if they were out of the building and in the sleeping quarters.

According to an interview on 11/2/22, at 12:58 p.m. LPN-B stated she was aware, on 10/14/22, that the RN scheduled to replace her in the morning had not shown up for work. LPN-B stated she "stayed a little late to finish charting" on that day. LPN-B stated she had "attended to the needs of the patients", but would not confirm if she had given any resident their insulin dose, and stated she did not know why the insulin doses were signed off as having been given by a different nurse. LPN-B stated she had seen TMA-A and TMA-B in the building and said they were both passing medications, but she did not know if TMA-A was able to give insulin in her role or not. LPN-B stated she had not told anyone when she left the building to go to the sleeping area as "I understood another nurse was coming in to replace me." LPN-B stated she did not know if her replacement had arrived by the time she

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left. LPN-B stated she was not using the time-clock at that time as she was quite new, and instead was "signing in and signing out on a time slip [paper]." LPN-B denied knowing the computerized record showed she was working from 6:15 a.m. to 2 p.m. on 10/14/22, and further stated she was not paid when in the sleeping quarters, saying, "when I'm off, I'm off."

According to an interview on 11/2/22, 2:25 p.m. RN-B stated she had been working the overnight shift with LPN-B from 10/13/22 until the morning of 10/14/22. RN-B stated she had been filling the nursing assistant shift. RN-B stated she had been aware that the relief nurse did not show up for his shift on the morning of 10/14/22, but stated she left the building in the morning, thinking it was about 6 a.m. RN-B stated she worked for the corporate entity, but did help fill in some of the work shifts at time, but stayed in a different city. RN-B stated she often had poor phone service after leaving the facility, and did not get any communications sent to her about needing a nurse until later in the day, but she was not sure of the time. RN-B stated she had returned to the building later to work a 2 p.m. to 6 p.m. shift, but stated she was not sure when she had entered the building. RN-B stated she did not have access to the time-clock so wrote out her times worked on a paper form that she signed. RN-B stated she had not been in the building when the morning insulin was to be given and could not recall why she had signed off the insulin doses to R2,R4, R5 and R7. RN-B further stated she could not recall why her initials were showing on R3's electronic MAR indicating she had been the one to give his morning medications via g-tube on 10/14/22. RN-B stated she had not given any morning medication and had not done any treatments that morning. RN-B stated she would

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not administer any morning medications that were marked as late without first assessing the resident's physical condition and whether the medication could be given later than ordered. RN-B stated she could recall that there were a lot of medications showing up in red, meaning they had been missed or were late, and if she had signed them, she "signed in error." RN-B did not recall if there was a nurse in the building when she arrived on 10/14/22 and said she would not have received shift to shift report as it was simply done on a piece of paper and not given nurse to nurse. RN-B stated she did recall staff saying to her, "thank-you for coming in."

According to an interview on 11/2/22, 2:41 p.m. DON stated she recalled a conversation she had had with NA-A on 10/14/22 regarding staffing concerns. She recalled being told there were two TMAs on the schedule, TMA-A and TMA-B. DON stated TMA-A used to be a nurse, but was not any longer. DON stated a TMA was not able to give insulin or do any treatments such as wound care and had never been informed that this had occurred. DON stated she was not aware, at the time, that there had not been a nurse in the building, and said there should have been. DON stated she recalled being told later that LPN-A had come to the building, and had stayed about 30 minutes before leaving. DON stated she understood LPN-A had not stayed because there was not an RN in the building. DON stated an expectation for the RDOP to have been notified, but said she was not sure where the RDOP was on that day or if she would have been able to come to the building.

According to an interview on 11/3/22, 9:29 a.m. TMA-A stated she worked in the facility in the laundry, worked as a nursing assistant and also

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PINE VIEW REHABILITATION AND SENIOR LIV	**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) COMPLETE DATE
2 820	Continued From page 23	2 820		

as a TMA. TMA-A stated she had been an LPN at one time, but it had been, perhaps as long as 8 years since she had practiced. TMA-A stated she no longer does any nursing continuing education. TMA-A stated she was in the building on the laundry schedule on 10/14/22, but also came to the dining room to assist the residents with their breakfast between 8 a.m. and 8:30 a.m. TMA-A stated NA-A told her LPN-B had been providing some cares to R3, and then was going to go to the sleeping quarters and there was not a nurse in the building. TMA-A stated she did not see LPN-B that morning. TMA-A stated NA-A told her she was unable to locate a replacement for a day shift left empty when an RN did not show up to replace LPN-B, and stated NA-A asked if TMA-A could give R3 his medications. TMA-A stated she told NA-A "technically, I cannot because they are given through a tube," but said NA-A replied, "but you know how," and "it's the only way he will get them." TMA-A stated she then gave R3 his medications via his G-tube, knowing she was not licensed, but out of concern for R3. TMA-A then stated she started checking the BG levels of diabetics, and then did administer insulin as she was concerned for the residents. TMA-A also stated she did her best to maintain the patency of R3's tracheostomy, urging him to cough out secretions to keep the airway open. TMA-A stated if his airway had come blocked she would have had to suction his airway which was a nursing function. TMA-A stated she was unsure what they were to do since there was not a nurse in the building.

TMA-A stated LPN-A had come to the building around 10 or 10:30 a.m. but had not punched in for work. TMA-A stated she understood LPN-A had a personal appointment, and things to do at home and was not available to work a full shift.

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2 820	Continued From page 24 TMA-A stated she understood LPN-A would have had to stay until 6:00 p.m. until RN-B returned to the facility and would have had to miss her own personal commitments. TMA-A stated she understood that a nurse was always to wait for their replacement or it was considered "patient abandonment" and the nurse might lose their license for that. TMA-A said she understood from NA-A that the RDOP had been notified. TMA-A started to cry and said she understood LPN-B had remained "punched in" on the time clock so it looked like a nurse was on duty, but TMA-A stated there was no nurse to take care of the residents, and further stated, "It was a terrible situation that day; I was so nervous and so scared. I just kept saying this isn ' t right, we shouldn ' t have to do this [work without a nurse]." According to an interview on 11/3/2, 11:31 a.m. the medical director (MD)-A stated, per his contract, he was supposed to be in the building at least monthly to attend the facility quality assessment and performance improvement meetings but this was spotty due to a turnover in administrative leadership in the building. MD-A stated he thought he had last been in the building sometime in September. MD-A stated he had not been notified that the facility had not had a nurse on duty for some hours on 10/14/22. MD-A stated he had many concerns upon learning that information as the facility had a number of residents with high medical acuity. MD-A stated R3 came to mind as someone who was "quite ill" and could not "be an advocate for himself." MD-A stated leaving R3 without a nurse on duty was "a major error." MD-A stated a concern with an unlicensed person giving insulin without being licensed even if that person had given insulin in the past. MD-A stated, "regardless of experience, they are unlicensed and that should not have	2 820		

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occurred." MD-A stated his specific concerns related to insulin were "the accuracy of the insulin dose being provided. Are they giving the correct amount? Insulin can be quite dangerous if given inappropriately." MD-A also stated a nurse sleeping nearby was not to be counted as nursing coverage as sleeping could not be construed as "being on duty" and if there was an emergency it would still take time for staff to go to that area, wake the person and bring them back to the facility.

A request was made for the facility nursing schedule for October of 2022 including any changes made since it was posted. A review of the week of 10/9/22 through 10/15/22 was done and revealed the following:
-the facility scheduler had written at the top of the page, "*no open shifts"
-RN-C was not listed as scheduled to work on 10/14/22
-LPN-B was listed as picking up a shift from 6 p.m. on 10/13/22 through 6:15 a.m. on 10/14/22
-LPN-B was also listed as scheduled to work 6:15 a.m. on 10/14/22 through 2 p.m. (this would have been a 20 hour shift)
-LPN-B was scheduled to return to work six hours after the 20 hour shift, to work an additional eight hour shift starting at 8 p.m. This was to provide direct care as a "nursing assistant."
-RN-B was listed as working a "nursing assistant" shift from 10 p.m. on 10/13/22 through 6:15 a.m.
-RN-B was listed as scheduled to work an RN shift from 2:15 p.m until 10 p.m. on 10/14/22, and then continue working until 4:15 a.m. as a "nursing assistant."

Further review of the facility schedule revealed TMA-A was not listed as scheduled to work as a TMA or nursing assistant on 10/14/22. LPN-A was

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also not listed on the schedule for 10/14/22.

A request was made for the handwritten time-sheet records of LPN-B. The facility provided a form titled Pine View Rehabilitation & Senior Living Time sheet adjustment request. The form indicated, "please adjust the time sheet for the date indicated (please put actual times worked, not scheduled times.)" The scheduled shift indicated LPN-B worked 10/13/22 from 6 p.m. until 6 a.m. The 6 a.m. was crossed off and 8 a.m. was written in as a correction and the reason listed was "short staff." The time-sheet adjustment was signed by LPN-B on 10/13/22 and co-signed by RN-B on 10/14/22.

A request was made for the handwritten time-sheet records of RN-B. The facility provided a form with the title of a different facility at the top; however, RN-B had written "Pineview" on the form dated 10/13/22. The 10/13/22 form indicated RN-B worked from 9:30 p.m. on 10/13/22 and signed out at 6:00 a.m. The form was signed by RN-B with no supervisor's signature. The time-sheet for 10/14/22 indicated RN-B started working at 2:00 p.m. and took a break from 7:00 p.m. and then worked from 8:00 p.m. until 4:15 a.m. This was also signed by RN-B, but not by a supervisor.

A request was made for a print out of the digital time-clock record of hours worked. This record indicated the facility paid LPN-B for hours worked from 6:00 p.m. until 6:00 a.m. on 10/13/22, and from 6:00 a.m. through 2:00 p.m. on 10/14/22 and then from 7 p.m. on 10/14/22 until 7 a.m. on 10/15/22. The digital print out of the time-clock record indicated RN-B was paid from 9:30 p.m. on 10/13/22 until 6:00 a.m. on 10/14/22, and then again on 10/14/22 from 2:00 p.m. until 4:15 a.m.

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on 10/15/22.

A request was made for a time-stamped record of medication administration times for R2 on 10/14/22. This record indicated RN-B had signed R2's Novolog (rapid acting insulin) Flexpen, 2 units for the morning medication pass at 4:13 p.m. This record also indicated RN-B signed the same medication and same amount for the noon med pass, but also signed this at 4:13 p.m. The record also indicated RN-B documented R2's Basaglar (slow acting insulin) Kwik Pen, 30 units, for the morning medication pass at 4:10 p.m. RN-B also documented having given 25 units of the Basaglar in the afternoon, documenting this as having been given at 5:31 p.m.

A request was made for the time-stamped record of medication administration times for R3, R4, R5, and R7 on 10/14/22, but these were not provided.

The Facility Assessment Tool, not signed or dated, indicated the facility had three 8 hour shifts per day, and for all shifts, "there is an LPN or an RN on the floor."

An additional 40 page document titled, "staffing standards for Pine View Rehabilitation & Senior living" was provided. This document indicated it was compiled in 2008 by the University Of California and consisted of "nursing home staffing standards in state statutes and regulations." The document further indicated it was based on a facility with 100 beds. The document indicated the expectation for the state of Minnesota was "sufficient numbers & adequate to the needs." The document did not address the federal regulations for skilled nursing facilities under a skilled facilities certification by the Centers of

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Medicare and Medicaid.

SUGGESTED METHOD OF CORRECTION:
The DON or designee could provide additional training to staff who do scheduling of nursing staff to ensure a nurse is scheduled for every facility shift. DON or designee could provide additional training to nursing staff regarding expectations for nursing coverage, and provide a plan for emergency back-up so the facility always has a nurse on duty in the facility. This plan could include information on what to do if a person does not come in for their scheduled shift, and expectations of staff who indicate they will work, but then do not. DON could meet routinely with the staffing coordinator to identify areas of weakness in the nursing schedule, and work on a plan to address those concerns.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.