Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 11, 2024

Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: CCN: 245516
Cycle Start Date: June 7, 2024

Dear Administrator:

On July 10, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2024

Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

Re: Reinspection Results
Event ID: NN8U12

Dear Administrator:

On July 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 7, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: CCN: 245516
Cycle Start Date: June 7, 2024

Dear Administrator:

On June 7, 2024, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 7, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 7, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

Re: State Nursing Home Licensing Orders
Event ID: NN8U11

Dear Administrator:

The above facility was surveyed on June 7,2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245516	A. BUILDING _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CENTER	700 JAMES AVENUE MANKATO, MN 56001

(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 6/7/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H55163603C (MN00103005), H55163580C (MN00103044) and H55164401C (MN00099412, MN00099332), with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		7/5/24

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

Electronically Signed | 06/27/2024

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

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F 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow physician orders related to weight gain, and monitor and assess edema (a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body) for 1 of 1 resident (R2) reviewed for fluid overload. Findings include R2's face sheet dated 6/7/24, identified R2 had diagnoses that included congestive heart failure. R2's physician orders included the following -2000 mL (milliliters) fluid restriction, 1080 mL for dietary and 920 mL for nursing (start date 12/16/23). -Compression stockings on in the morning (AM) and off at night (HS) (start date 1/2/24). -Daily weights. Update provider if weight gain of greater than two pounds in one day or five pounds in one week in the am for hypertensive heart disease (start date 3/1/24). R2's care plan dated 9/5/23, identified a goal to follow fluid restriction with the restriction of 2000mL of fluid per day with 1080mL from dietary and 920mL from nursing. R2's occupational therapy (OT) discharge summary dated 8/9/23, identified at discharge R2 would need assistance with socks and shoes as needed due to bilateral leg wraps. R2's physician note dated 6/3/24, identified R2 had been wearing compression socks that he purchased himself from home. Fluid restriction	F 684	R2 was assessed for fluid overload, provider was updated on current condition, and care plan was reviewed and updated, as appropriate. Provider discontinued R2's fluid restriction on 06/18/24. All residents at risk for fluid overload have the potential to be affected. A full house audit was completed to identify residents at risk for fluid overload to ensure appropriate orders were in place, monitoring was completed, and provider was updated, as appropriate. The facility reviewed the MHM Notification of Changes, MHM Activities of Daily Living/Maintain Abilities, and MHM Care Planning policies. Nursing staff have been educated on the facility protocols for daily weight monitoring, edema monitoring, fluid intake monitoring, provider updates regarding weight, application of compression stockings, and thorough documentation. Culinary staff have been educated on the facility protocol for fluid intake monitoring and thorough documentation. Director of Nursing or designee will conduct random audits of residents at risk for fluid overload to ensure compliance with facility policies and protocols. Audits will be conducted daily x5, weekly x4, monthly x2 and reported to QAPI committee for further review and recommendations.	

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F 684	Continued From page 2	F 684		

needed due to his heart failure and risk of exacerbation if he drinks too much fluid, ok to discontinue wraps and use compression stockings-on in AM off at HS.

R2's weight log from 5/13/24-6/7/24 identified R2 weighed 224.5 pounds (#) on 5/23/24, no weight obtained on 5/24/24, and on 5/25/24 weighed 227#. This identified a weight gain of 2.5#. No indication of the physician being notified of weight gain. On 6/3/24 weight was 227# and on 6/4/24 weight was 231#. This identified a weight gain of 4# in one day. No indication that physician was notified of the weight gain.

R2's Treatment Administration Record (TAR) identified day, evening, and night shifts to fill in how much fluid was consumed for each shift. The TAR identified missing recorded entries for fluid consumption and shifts and was not evident evaluations of 24-hour intake totals were completed.
-On 5/3/24, day and evening shifts were not filled out and night shift recorded sleep.
-On 5/19/24, day shift filled out 200 mL with nothing marked on the other two shifts.

R2's record did not include edema assessments or monitoring.

During an observation and interview on 6/7/24 at 9:22 a.m., R2 sat on the edge of his bed without pants on exposing his legs. R2 pressed his fingers into his lower shins, the area stayed indented for approximately one minute (3+ pitting edema). R2 stated he had been using his compression socks and they seemed to help. "Staff have not been putting them on, when my legs are really swollen, they say "Oh I am busy.",

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LAURELS PEAK CARE & REHABILITATION CENTER	700 JAMES AVENUE MANKATO, MN 56001

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F 684	Continued From page 3 so I either put them on myself or I am done with it. I do not ask anymore. I am getting to the point that if my legs do swell up I do not even care. Like today they are a little swollen but not bad." "I bought these black compression socks from Walmart and that is what I use." During an interview on 6/7/24 at 3:22 p.m., licensed practical nurse (LPN)-A stated resident weights were completed in the morning. LPN-A did not typically look at the weights, only if it was indicated through shift report. If LPN-A noticed a difference in R2's edema she would pass it on to the next shift but would not document her findings in the medical record. LPN-A explained R2 had a big water bottle that he carried around with him, so most of the documentation for R2's fluid intake was from asking him how much he consumed. Staff would provide R2 with a half a cup of liquid with his bedtime medications and an 8 ounces of a dietary supplement with his evening medications. LPN-A was not aware if any nursing or dietary staff were evaluating R2's daily total fluid consumption. LPN-A removed R2's compression socks and shoes and reported R2's right foot had was trace edema with 1-2+ edema around the ankle area. On R2's left foot there was trace edema, inner ankle +3 and outer ankle +2. LPN-A indicated that they do not have any way to know what R2's edema was at for measurements because it had not been documented. During an interview on 6/7/24 at 10:56 a.m., trained medication aide (TMA)-A stated the nursing assistants (NA) usually get the resident weights and write them down on a paper and would give the paper to the nurse. TMA-A stated sometimes the nurse would put the weights in the computer but most of the time the NA's recorded	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 4	F 684		

the weights. TMA-A stated technically any staff could apply ace wraps but usually the nurse would do it.

During an interview on 6/7/24 at 11:01 a.m., registered nurse (RN)-A stated she was aware that R2 wore the black compression socks. RN-A would document refused in the TAR if R2 refused to wear them. RN-A was not aware of any instruction/direction to monitor edema, if it was being completed and/or documented. RN-A stated that she would not put his compression socks on but would check to make sure he was wearing them then sign off in the computer. RN-A was not able to find a progress note or physician notification pertaining to R2's weight gain as directed by the physician order.

During an interview on 6/7/24 at 11:21 a.m., RN-B indicated nursing did not complete daily charting on edema, but would do standard checking, if appropriate. RN-B reviewed R2's record, RN-B confirmed the physician was not notified of the weight gain. RN-B indicated if there was a noted weight gain that needed to be communicated to the physician the nurse should also assess lung sounds, vital signs, and location and extent of edema if present.

During an observation on 6/7/24 at 11:31 a.m., R2 was in the dining room for the noon meal. R2 did not have any beverages. At 11:36 a.m., R2 received his meal but not any beverages. R2 pulled a large 64-ounce beverage container from his electric wheelchair and reported it was filled with juice.

During an interview on 6/7/24 at 3:37 p.m., culinary director (CD)-A stated when she received

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F 684	Continued From page 5 the order for a fluid restriction the allotted amount for dietary was 1080 mL and 920 mL for nursing staff. CD-A explained dietary staff would record intake from dietary however, most of the time the amounts were recorded in percentages versus milliter's consumed. CD-A was not aware if nursing staff monitored the fluid intake from dietary staff or if they were only documenting the amounts that nursing provided. During an interview on 6/7/24 at 3:46 p.m., director of nursing (DON) stated R2 was pretty independent. He had access to water in his room and water fountains in the building. R2 would also have food/beverages delivered to the facility. DON stated dietary only recorded drinks provided by the dietary department, so if R2 were to bring his own beverage they would not add that in with the amount he drank. DON stated typically if there was a fluid restriction the allowance would be divided between shifts. DON explained the facility did not have a 24-hour look back log for further evaluating compliance with the restriction. DON expected nursing staff complete the weights as ordered by the medical doctor and notify the provider of the weight gain if it fell within the parameters of notification. Edema was not typically monitored daily on every resident but should be monitored for certain residents that had edema so the provider could be notified if there were changes. The facility Fluid Restriction Guidelines dated 9/2012, identified guidelines for 1000 mL or less and 1500 mL fluid restrictions. Fluid restrictions would be done with doctors' orders only, and intake would be measured every shift. The facility Notification of Changes Policy dated	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAURELS PEAK CARE & REHABILITATION CENTER	700 JAMES AVENUE MANKATO, MN 56001

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F 684	Continued From page 6 3/2024, identified that a change in resident's condition or treatment be reported to the attending physician or delegate. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification to ensure the best outcomes of care for the resident. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition in a timely manner to the parties who will make decisions about care, treatment, and preferences to address the changes.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00035	A. BUILDING: _____ B. WING _____	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CE	700 JAMES AVENUE MANKATO, MN 56001

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/7/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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	00035	A. BUILDING: _____ B. WING _____	06/07/2024

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LAURELS PEAK CARE & REHABILITATION CE	700 JAMES AVENUE MANKATO, MN 56001

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55163603C (MN00103005), H55163580C (MN00103044) and H55164401C (MN00099412, MN00099332) with a licensing order issued at 0830. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow physician orders related to weight gain, and monitor and assess edema (a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body) for 1 of 1 resident (R2) reviewed for fluid overload. Findings include	2 830	Corrected.	7/5/24

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2 830	Continued From page 3 R2's face sheet dated 6/7/24, identified R2 had diagnoses that included congestive heart failure. R2's physician orders included the following -2000 mL (milliliters) fluid restriction, 1080 mL for dietary and 920 mL for nursing (start date 12/16/23). -Compression stockings on in the morning (AM) and off at night (HS) (start date 1/2/24). -Daily weights. Update provider if weight gain of greater than two pounds in one day or five pounds in one week in the am for hypertensive heart disease (start date 3/1/24). R2's care plan dated 9/5/23, identified a goal to follow fluid restriction with the restriction of 2000mL of fluid per day with 1080mL from dietary and 920mL from nursing. R2's occupational therapy (OT) discharge summary dated 8/9/23, identified at discharge R2 would need assistance with socks and shoes as needed due to bilateral leg wraps. R2's physician note dated 6/3/24, identified R2 had been wearing compression socks that he purchased himself from home. Fluid restriction needed due to his heart failure and risk of exacerbation if he drinks too much fluid, ok to discontinue wraps and use compression stockings-on in AM off at HS. R2's weight log from 5/13/24-6/7/24 identified R2 weighed 224.5 pounds (#) on 5/23/24, no weight obtained on 5/24/24, and on 5/25/24 weighed 227#. This identified a weight gain of 2.5#. No indication of the physician being notified of weight gain. On 6/3/24 weight was 227# and on 6/4/24 weight was 231#. This identified a weight gain of 4# in one day. No indication that physician was	2 830		

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2 830	Continued From page 4 notified of the weight gain. R2's Treatment Administration Record (TAR) identified day, evening, and night shifts to fill in how much fluid was consumed for each shift. The TAR identified missing recorded entries for fluid consumption and shifts and was not evident evaluations of 24-hour intake totals were completed. -On 5/3/24, day and evening shifts were not filled out and night shift recorded sleep. -On 5/19/24, day shift filled out 200 mL with nothing marked on the other two shifts. R2's record did not include edema assessments or monitoring. During an observation and interview on 6/7/24 at 9:22 a.m., R2 sat on the edge of his bed without pants on exposing his legs. R2 pressed his fingers into his lower shins, the area stayed indented for approximately one minute (3+ pitting edema). R2 stated he had been using his compression socks and they seemed to help. "Staff have not been putting them on, when my legs are really swollen, they say "Oh I am busy.", so I either put them on myself or I am done with it. I do not ask anymore. I am getting to the point that if my legs do swell up I do not even care. Like today they are a little swollen but not bad." "I bought these black compression socks from Walmart and that is what I use." During an interview on 6/7/24 at 3:22 p.m., licensed practical nurse (LPN)-A stated resident weights were completed in the morning. LPN-A did not typically look at the weights, only if it was indicated through shift report. If LPN-A noticed a difference in R2's edema she would pass it on to the next shift but would not document her findings	2 830		

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2 830	Continued From page 5 in the medical record. LPN-A explained R2 had a big water bottle that he carried around with him, so most of the documentation for R2's fluid intake was from asking him how much he consumed. Staff would provide R2 with a half a cup of liquid with his bedtime medications and an 8 ounces of a dietary supplement with his evening medications. LPN-A was not aware if any nursing or dietary staff were evaluating R2's daily total fluid consumption. LPN-A removed R2's compression socks and shoes and reported R2's right foot had was trace edema with 1-2+ edema around the ankle area. On R2's left foot there was trace edema, inner ankle +3 and outer ankle +2. LPN-A indicated that they do not have any way to know what R2's edema was at for measurements because it had not been documented. During an interview on 6/7/24 at 10:56 a.m., trained medication aide (TMA)-A stated the nursing assistants (NA) usually get the resident weights and write them down on a paper and would give the paper to the nurse. TMA-A stated sometimes the nurse would put the weights in the computer but most of the time the NA's recorded the weights. TMA-A stated technically any staff could apply ace wraps but usually the nurse would do it. During an interview on 6/7/24 at 11:01 a.m., registered nurse (RN)-A stated she was aware that R2 wore the black compression socks. RN-A would document refused in the TAR if R2 refused to wear them. RN-A was not aware of any instruction/direction to monitor edema, if it was being completed and/or documented. RN-A stated that she would not put his compression socks on but would check to make sure he was wearing them then sign off in the computer. RN-A was not able to find a progress note or physician	2 830		

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2 830	Continued From page 6 notification pertaining to R2's weight gain as directed by the physician order. During an interview on 6/7/24 at 11:21 a.m., RN-B indicated nursing did not complete daily charting on edema, but would do standard checking, if appropriate. RN-B reviewed R2's record, RN-B confirmed the physician was not notified of the weight gain. RN-B indicated if there was a noted weight gain that needed to be communicated to the physician the nurse should also assess lung sounds, vital signs, and location and extent of edema if present. During an observation on 6/7/24 at 11:31 a.m., R2 was in the dining room for the noon meal. R2 did not have any beverages. At 11:36 a.m., R2 received his meal but not any beverages. R2 pulled a large 64-ounce beverage container from his electric wheelchair and reported it was filled with juice. During an interview on 6/7/24 at 3:37 p.m., culinary director (CD)-A stated when she received the order for a fluid restriction the allotted amount for dietary was 1080 mL and 920 mL for nursing staff. CD-A explained dietary staff would record intake from dietary however, most of the time the amounts were recorded in percentages versus milliter's consumed. CD-A was not aware if nursing staff monitored the fluid intake from dietary staff or if they were only documenting the amounts that nursing provided. During an interview on 6/7/24 at 3:46 p.m., director of nursing (DON) stated R2 was pretty independent. He had access to water in his room and water fountains in the building. R2 would also have food/beverages delivered to the facility. DON stated dietary only recorded drinks provided	2 830		

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2 830	Continued From page 7 by the dietary department, so if R2 were to bring his own beverage they would not add that in with the amount he drank. DON stated typically if there was a fluid restriction the allowance would be divided between shifts. DON explained the facility did not have a 24-hour look back log for further evaluating compliance with the restriction. DON expected nursing staff complete the weights as ordered by the medical doctor and notify the provider of the weight gain if it fell within the parameters of notification. Edema was not typically monitored daily on every resident but should be monitored for certain residents that had edema so the provider could be notified if there were changes. The facility Fluid Restriction Guidelines dated 9/2012, identified guidelines for 1000 mL or less and 1500 mL fluid restrictions. Fluid restrictions would be done with doctors' orders only, and intake would be measured every shift. The facility Notification of Changes Policy dated 3/2024, identified that a change in resident's condition or treatment be reported to the attending physician or delegate. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification to ensure the best outcomes of care for the resident. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition in a timely manner to the parties who will make decisions about care, treatment, and preferences to address the changes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with edema, to assure they are receiving ongoing monitoring and assessment of	2 830		

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2 830	Continued From page 8 the edema along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		