DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 20, 2021

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: CCN: 245556
Cycle Start Date: June 14, 2021

Dear Administrator:

On August 16, 2021, the Minnesota Department(s) 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 6, 2021

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: CCN: 245556
Cycle Start Date: June 14, 2021

Dear Administrator:

On June 14, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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" tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 14, 2021 (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 14, 2021 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	C 06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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 6/9/21 through 6/11/21 and 6/14/21, 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 complaints were found to be SUBSTANTIATED: H5556053C (MN00058102, MN00057840, MN00057892, MN00057906) with deficiences cited at F550 and F690. H5556054C (MN00058416) with deficiences cited at F550 and F690. H5556055C (MN00073568) with deficiences cited at F550 and F690. H5556056C (MN00072937) with deficiences cited at F550 and F690. H5556057C (MN00072348) with deficiences cited at F550, F584, and F690. H5556058C (MN00071877) with deficiences cited at F550 and F690 H5556059C (MN00071807) with deficiences cited at F690 H5556060C (MN00071440) with deficiences cited at F584. H5556061C (MN00059285) with deficiences cited at F550 and F690 H5556062C (MN00064121) with deficiences cited at F550 and F690 H5556063C (MN00071352) with deficiences cited at F550, F584, and F690. H5556064C (MN00071195) with deficiences cited at F550 and F690. H5556065C (MN00063570) with deficiences cited at F550 and F585.	F 000		

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

Electronically Signed | 07/15/2021

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F 000	Continued From page 1 H5556067C (MN00061945) with deficiences cited at F550 and F584. H5556068C (MN00061908) with deficiences cited at F550. H5556070C (MN00060561) with deficiences cited at F550. H5556071C (MN00058665) with deficiences cited at F550 and F690 H5556066C (MN00063317) with no deficiences cited. H5556069C (MN00061766) with no deficiences cited. H5556072C (MN00073783) with no deficiences cited. 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 substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		8/6/21

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F 550	Continued From page 2 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignified clothing for 1 of 3 resident (R6) who expressed they would prefer not to wear soiled clothing.	F 550	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a	

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F 550	Continued From page 3 Findings include: During continuous observation on 6/10/21, at 8:38 a.m. through 8:55 a.m. registered nurse (RN)-B entered R6's room with morning medications; R6 stated his "butt is sore." RN-B instructed R6 to turn on his side so she could place Lidocaine patches. As R6 turned on his left side, he grabbed the top of the adult incontinence brief he was wearing, pulled on it, and emphatically stated, "this is wet. I want to go to the bathroom." RN-B suggested he take his medications first and R6 stated, "I'm wet!" RN-B then assisted R6 to the bathroom where she removed R6's soiled brief and sweatpants. After RN-B cleaned R6 and placed a new brief, she redressed R6 in the soiled sweatpants. R6 stated, "they're damp." RN-B stated there were no other clothes and R6 said it was okay because he didn't want to just wear a brief. R6's care plan dated 6/2/21, indicated R6 wanted to be clean and well-dressed every day, requiring assistance of one with hygiene. The care plan also indicated R6 was incontinent of urine but was not on a toileting schedule; it indicated he could ask for assistance. During an interview on 6/10/21, at 8:55 a.m. R6 stated he did not usually wear incontinence briefs but sometimes he can't just hold it and staff are slow to answer call lights; they started using the product on him shortly after he arrived at the facility but doesn't remember which day. R6 stated his preference was to go to the bathroom rather than "wear a diaper like a baby." R6 wasn't sure if he had any clean, dry pants and stated his preference was not to put soiled pants back on if	F 550	credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F550 Resident Rights/Exercise of Rights Immediate Corrective Action: RN-B received coaching and re-education on resident rights and the perineal care policy/procedure. Corrective Action as it Applies to Other Residents: The perineal care policy/procedure was reviewed by Clinical and Care Center Administrator. All Care Center nursing staff were reeducated on resident rights as it relates to dignity and the Perineal care policy/procedure. Reoccurrence will be Prevented By: IDT will complete weekly perineal care audits as well as weekly resident dignity audits for 12 weeks. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits. Date certain: 08/06/2021	

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F 550	Continued From page 4 he did have clean pants. During an interview on 6/10/21, at 8:57 a.m. RN-B stated she did not know if R6 had any clean pants as this was the second time, she provided care for him; she put on the damp pants because she thought he would want to have pants on. During an interview on 6/14/21, at 3:08 p.m. the director of nursing (DON) stated her expectation was staff would not dress residents in soiled clothing; rather, would dress residents in clean clothing. The facility's Perineal Care Policy dated June 2021, indicated staff were to remove and dispose of wet/soiled articles in an appropriate container after removing from a resident.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		8/6/21

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F 584	Continued From page 5 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to keep the resident bathroom clean for 1 of 3 residents (R1) reviewed for a clean, homelike environment. Findings include: R1's admission Minimum Data Set (MDS) dated 6/7/20, identified R1 had severe cognitive impairment and diagnoses which included frequent urinary tract infections (UTI), anxiety, metabolic encephalopathy, major depression, and chronic kidney disease. The MDS also indicated R1 was always incontinent of urine and frequently incontinent of feces and required extensive	F 584	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	

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F 584	Continued From page 6 assistance with toileting and transfers. R1's care plan dated 4/12/21, indicated R1 had an activities of daily living (ADL) deficit and recurrent C-Diff infections (bacterial infection that causes diarrhea) but lacked interventions to maintain a clean, homelike environment. The Facility Cleaning Audit dated 4/29/21, indicated R1's room was found with dirty towels on the floor by shower and the handrails by R1's toilet had stool on it. During an observation on 6/9/21, at 9:40 a.m. housekeeper (HKP)-A was observed cleaning R1's room. During an observation on 6/9/21, at 12:01 p.m. R1's bathroom was observed with multiple areas of dried feces on the handles of the toilet seat riser, dried feces splattered on the right side of the wall when facing away from the toilet, and dried feces on the wall behind the toilet. The floor at the base of the toilet was observed to have a 1/4 inch of dark brown feces all the way around the toilet. Across from the shower just below the towel bar a roughly two-inch dried white spot of toothpaste was observed on the wall. Also observed in the bathroom, stacked between other items, was a pillow with a roughly 12-inch circular brown spot. During an interview on 6/9/21, at 11:44 a.m. family member (FM)-A stated R1's room was not cleaned like it should; "it was like the housekeeping staff are not even coming in sometimes." FM-A stated the bathroom was the worst part with the splattered spots of feces on the wall, toilet, around the toilet; dried toothpaste	F 584	F584 Safe/Clean/Comfortable/Homelike Environment Immediate Corrective Action: R1□s bathroom was cleaned. Full time housekeeper was provided with coaching per progressive discipline policy regarding expectations and responsibilities for bathroom cleanliness. Corrective Action as it Applies to Other Residents: Deep cleaning policy was reviewed by the Clinical and Care Center Administrators, Housekeeping supervisor, and Environmental Services Director. Facility housekeeping staff have been reeducated on the deep cleaning policy and a deep cleaning checklist was initiated to ensure all areas have been cleaned. Environmental Services Director has put together binders for each household which will include the monthly deep clean policy, schedules, checklist, and audits. All Care Center nursing staff have been reeducated on their role in maintaining resident room and resident bathroom cleanliness. Reoccurrence will be Prevented By: Environmental Services Director, Housekeeping supervisor or designee will be completing housekeeping audits on 10% of resident rooms weekly for 12 weeks. Audits will address room cleanliness, completion of checklist and compliance with the deep clean schedule.	

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F 584	Continued From page 7 one the wall; and a pillow with a large brown stain on it, just stacked next to the shower for months. FM-A stated R1 was prone to urinary tract infections, and she needed to have a clean environment. FM-A further stated some of these areas have been dirty for four months. During an interview on 6/9/21, at 1:30 p.m. licensed practical nurse (LPN)-A indicated housekeeping was responsible for cleaning toilet seat risers, walls, and floors in bathrooms. LPN-1 confirmed R1's bathroom wall had a two-inch round spot of dried toothpaste on the wall. LPN-A also verified their appeared to be feces around the base of toilet floor, on the wall, and on the toilet seat riser. LPN-A also verified a soiled pillow, stained light brown about 12 inches in a circular pattern but stated it could be from washing R1's hair. During an interview on 6/9/21, at 2:12 p.m. registered nurse (RN)- F stated housekeeping was responsible for cleaning the residents' room, but if a resident had loose stool, as R1 often did, it should be addressed by the aides or nursing staff immediately and not left for housekeeping. During an interview on 6/10/21, at 8:30 a.m. the director of housekeeping (DH) stated deep cleaning was scheduled and done once a month for each resident and once a day housekeepers would clean the bathroom, the floors, and remove the garbage. The DH stated the expectation was for the room to be deep cleaned and then signed off after the work was completed. The DH reviewed the calendar of deep cleaning scheduled for 6/10/21, which indicated R1's room was scheduled for deep cleaning, but it was already signed off the work was completed. After	F 584	Deep clean schedules will be audited by housekeeping supervisors on a weekly basis and kept with both Housekeeping supervisors to ensure completion of deep cleaning. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits. Date certain: 08/06/2021	

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F 584	Continued From page 8 inspection of R1's room, the DH confirmed there were spots of dried feces on the wall behind the toilet, the bars, and the back area of the toilet seat riser, and on the floor around the toilet. The DH stated when bathrooms got dirty it should be cleaned for the health and safety of the resident. During an interview on 6/14/21, at 3:08 p.m. the director of nursing (DON) stated all staff were responsible for keeping all areas cleaned for the residents to make it a homelike environment. The DON further stated cross contamination could occur if feces was on the handles of the toilet seat riser where staff could touch and then touch the resident during cares. The DON stated her expectation was staff would not wait for housekeeping but clean the feces up prior to housekeeping coming in the next day. The facility's Policy Deep Cleaning Resident Rooms dated 3/15/12, indicated resident's rooms would be deep cleaned on a scheduled basis to ensure rooms are cleaned and sanitized properly. The facility's PHS Housekeeping policy dated 10/1/18, directed staff to perform cleaning responsibilities above and beyond the daily minimum levels to prevent cross contamination.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		8/6/21

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F 585	Continued From page 9	F 585		

furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

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F 585	Continued From page 10 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

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F 585	Continued From page 11 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow up and provide written responses to resident concerns about responsiveness to call lights for 6 of 6 residents (R1, R7, R8, R9, R10, and R11) reviewed for grievances. Findings include: NO WRITTEN RESPONSE TO GRIEVANCE WHEN REQUESTED R1's quarterly Minimum Data Set (MDS) dated 4/7/21, indicated R1 had a Brief Interview of Mental Status (BIMS) score of 5, indicating severe cognitive impairment, and diagnoses of scoliosis, anxiety, and depression. The MDS also indicated R1 was always incontinent of urine and frequently incontinent of feces and required extensive assistance with toileting and bed mobility. R1's quality concern form dated 4/15/21, indicated R1 filed a written complaint, dated 4/14/21, in which she complained about her bed being made with "wet and soiled linens." In the written complaint, R1 wrote, "As I have requested previously, I am asking that I receive any response to this in a written form." The form indicated R1 was contacted on 4/14/21, for an update but there was no written response nor	F 585	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F585 Grievances Immediate Corrective Action: Quality Concern/Grievance process was reviewed by the Clinical and Care Center Administrators and updated to reflect the contact information of the grievance officer. Updated process was posted visibly at all nursing stations. Grievances cited for R1, R7, R8, R9, R10 and R11 were reviewed to ensure written follow up was provided to the resident or family member that completed the grievance	

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F 585	Continued From page 12 indication of what the resident was told in response to her grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file. The administrator stated grievances did not have to be responded to in writing. R1's quality concern form dated 4/21/21, indicated R1's daughter filed a verbal grievance about dried feces found on the soaker pad and fitted sheet. The section indicating follow-up was left blank. The administrator stated he was sure this was followed up on but was unsure why that section was blank. The administrator verified his signature on the form, indicating he reviewed the form. There was no written response to the grievance. INCOMPLETE WRITTEN RESPONSE TO GRIEVANCE R11's admission MDS dated 4/28/21, indicated R11 had a BIMS score of 7, indicating severe cognitive impairment and diagnoses of Alzheimer's disease and malnutrition. The MDS also indicated R11 was frequently incontinent of urine and required extensive assistance with toileting and bed mobility. R11's quality concern form dated 5/27/21, indicated R11 reported three staff members responded to her call light but her needs were not met for over 30 minutes and the nursing assistant (NA) informed her she could not assist because it was change of shift. The clinical coordinator's written response to F11's grievance lacked all components required for a written response to a grievance; missing were a summary statement of	F 585	form. Corrective Action as it Applies to Other Residents: SW-A received coaching per progressive discipline policy regarding informing residents of the Quality concern/Grievance process upon admission. The Quality concern/Grievance process has been added to all admission packets to ensure residents are aware of their rights to file a grievance. All departments were reeducated on the Quality concern/Grievance process. Quality concerns/Grievances will be reviewed daily with the IDT to ensure concerns are addressed promptly, are responded to in writing, and include all components of a written response. Concerns/Grievances submitted on the weekend will be discussed on Monday. Reoccurrence will be Prevented By: Audits will be completed on every grievance submitted for 12 weeks to ensure documentation of written follow up is provided to the person who initiated the process. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits Date certain: 08/06/2021	

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the grievance, steps taken to investigate the grievance, and how the grievance was resolved.

LACK OF WRITTEN RESPONSES TO GRIEVANCES

R7's quarterly MDS dated 12/29/20, indicated R7 had a BIMS score of 10, indicating moderate cognitive impairment, and diagnoses of debilitating heart failure, kidney disease, and dementia. The MDS also indicated R7 was frequently incontinent of bowel and urine and required extensive assistance with toileting and bed mobility.

R7's quality concern form dated 2/2/21, indicated R7 complained about the call light being on for six hours; it was answered several times, but no one helped her with blankets or toileting. The form indicated R7 was contacted on 2/2/21, for an update but there was no written response nor indication of what the resident was told in response to her grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file.

R8's admission MDS dated 2/24/21, indicated R8 had a BIMS score of 9, indicating severe cognitive impairment, and medical diagnoses of fractured left fibula, pneumonia, and dementia. The MDS also indicated R8 was frequently incontinent of urine and feces and required extensive assistance with toileting and bed mobility.

R8's quality concern form dated 3/29/21, indicated R8's family member (FM)-C had numerous concerns including long call light wait

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times (on 3/27/21, and again on 3/29/21), using a wastebasket to prop up R8's foot during wound care, unfriendly staff, lack of updating of the care board, and a nurse hanging up on the daughter when she called the facility on 3/5/21. The form indicated R8's FM-C was contacted on 3/29/21, for an update but there was no written response nor indication of what the resident was told in response to the grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file.

R9's admission MDS dated 5/18/21, indicated R9 had a BIMS score of 15, indicating intact cognitive and diagnoses of fractured hip, pneumonia, and heart failure. The MDS also indicated R9 was frequently incontinent of urine and feces and required extensive assistance with toileting and bed mobility.

R9's quality concern form dated 5/11/21, indicated R9, FM-M, and FM-B were concerned about R9's call light wait times (up to an hour) since 5/3/21 and when NA responded, NA told R9 to "urinate in his brief." The form indicated R9, FM-A, and FM-B were contacted on 5/11/21 for an update but there was no written response nor indication of what the resident was told in response to his grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file.

R10's admission MDS dated 4/13/21, indicated R10 had a BIMS score of 15, indicating intent cognitive and medical diagnoses of sacral (lower back/tailbone) fracture. The MDS also indicated

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R10 was frequently incontinent of urine and required extensive assistance with toileting and bed mobility.

R10's quality concern form, dated 5/24/21, indicated R10 reported a female NA told her she used the call light too much. The form indicated R10 was contacted on 5/24/21, for an update but there was no written response nor indication of what the resident was told in response to her grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file.

During an interview on 6/10/11/21, in the afternoon, the administrator stated at some point they stopped taking R1's grievances and just started making a list of complaints. The administrator did not recall how those complaints were processed or resolved.

During an interview on 6/14/21, at 10:42 a.m. social worker (SW)-A stated she did not discuss the grievance process when residents were admitted to the facility because the facility did not want them to think the facility was a bad one because they had grievances. SW-A stated if a complaint could not be resolved, she would then inform them they could complete a Quality Concern Form and she would assist them with the form. SW-A stated R1's family member (FM)-A filed so many complaints, they just started keeping a list rather than treat each one as a grievance.

During an interview on 6/14/21, at 5:53 p.m. the administrator stated he was the Grievance Officer. The administrator was not sure where he

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was listed as the grievance officer to the residents and verified the Quality Concern Form did not identify him as the Grievance Officer or provide any contact information for the Grievance Officer. The administrator stated verbal grievances were not responded to in writing, but if a resident requested, they would get a response in writing; if an e-mail, they would respond via e-mail. The administrator verified only R11's grievance had a written response and R1's 4/21/21, form did not indicate a follow-up. The administrator verified R1's 4/15/21, form, and R7, R8, R9, and R10's forms indicated follow-up was completed with the resident, but he did not know what the follow-up entailed; he verified he signed each Quality Concern Form indicating he had reviewed handling of the grievance. The administrator stated the facility was working on call light response times and had a plan for reducing wait times from six minutes to five minutes. The administrator could not answer how they were working to reduce the time it took to meet the residents' toileting needs after the call light was answered. The administrator stated it was his expectation the social workers would inform the residents of their rights to file a grievance upon admission, assist residents with writing grievances, and have a grievance form for each grievance.

The facility's grievance policy dated September 2020, indicated the administrator was the Grievance Officer but lacked the administrator's name and contact information in the policy or on the Quality Concern Form, which was the form used for grievances. The policy indicated all grievances would be addressed within five working days and action items would be communicated to the individual filing the

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F 585	Continued From page 17 grievance. The policy lacked any actions related to a written response to a grievance or what a written response to a grievance should contain.	F 585		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		8/6/21

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F 690	Continued From page 18 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate incontinent care for 1 of 3 residents (R6) reviewed for incontinence care. Findings include: During continuous observation on 6/10/21, at 8:38 a.m. through 8:55 a.m. registered nurse (RN)-B assisted R6 to the bathroom where she removed soiled brief and sweatpants. RN-B asked R6 to sit on the closed toilet seat cover so she could get the nurse practitioner (NP) to inspect his rectal area and he asked her to place a towel on the seat first. RN-B returned and stated the NP was busy so she would clean R6 and not place any barrier cream or dressings. R6 stated he needed to be wet wiped and cleaned. RN-B stated she wanted to put his Lidocaine patches on first and proceeded to apply one Lidocaine patch on each upper gluteal area. R6 stated that was not where his pain was, it was where he sat. After the patches were in place, RN-B assisted R6 to standing where she performed peri care with wet wipes. She cleaned his gluteal areas under the patches, then his rectal area, using an up and down motion in the rectal area. RN-B then cleaned his front, cleaning under his scrotum first and then his penis. R6's admission Minimum Data Set (MDS) dated 6/8/21, identified R6 had intact cognition. The MDS also indicated R6 was occasional incontinent of urine and required extensive assistance of one staff for toileting and transfers.	F 690	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate Corrective Action: Perineal Care policy/procedure was reviewed by the Clinical and Care Center Administrators. RN-B was provided with coaching per progressive discipline policy and was reeducated on the perineal care policy/procedure. Corrective Action as it Applies to Other Residents: All nursing staff were reeducated on the perineal care policy/procedure. Microlearning education on □Understanding Urinary Tract Infections□ was initiated for all nursing staff. Microlearning education on	

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F 690	Continued From page 19 R6's diagnosis list dated 5/6/21, indicated R6 had diagnoses of chronic low back pain, left hip pain, and spinal stenosis in the lower back. R6's care plan dated 6/2/21, indicated R6 wanted to be clean and well-dressed every day, requiring assistance of one with hygiene. The care plan also indicated R6 was incontinent of urine but was not on a toileting schedule; and he could ask for assistance. R6's Bowel, Bladder, and Skin Risk Summary and Analysis note dated 6/3/21, indicated R6 did not use an incontinent product was continent of urine, could identify the need to urinate, and could use the call light to request assistance. R6's Wound Assement note dated 6/8/21, indicated R6 had moisture associated skin damage (MASD) on his coccyx. R6's PN dated 6/11/21, indicated R6 had urge bladder incontinence (sudden intense urge to urinate followed by involuntary release of urine). R6's PN dated 6/15/21 indicated R6 could make his needs know, used a call light for help, and was continent of bowel and bladder. During an interview on 6/10/21, at 8:55 a.m. R6 stated he got frustrated at times because they did not keep him clean and dry. He stated they would try, but sometimes they "just want to get things done." R6 also stated he did not normally use an incontinence brief, they started when he was admitted to the facility because sometimes, he could not hold it and he would wet himself.	F 690	□Appropriate Treatment for Urinary Tract Infections□ was also implemented for nurses. Reoccurrence will be Prevented By: Clinical Administrator, Clinical Coordinator, Infection Control and Prevention Specialist, or designee will complete random Perineal care audits on 10% of residents weekly on each household for 12 weeks. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits Date certain: 08/06/2021	

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F 690	Continued From page 20 During an interview on 6/10/21, at 8:57 a.m. RN-B stated she placed the Lidocaine patch before cleaning R6's gluteal area because he was in pain, and she wanted to help. RN-B verified perineal care on a male should begin with his genitals, cleaning from cleanest area first moving to the less clean area, and cleaning from front to back. RN-B stated was not sure why she cleaned his rectal area first. During an interview on 6/14/21, at 3:08 p.m. the director of nursing (DON) stated her expectation was staff would perform peri care prior to placing any patches or dressings on a resident. She also stated her expectation was staff would follow the Perineal Care Policy washing the penis, scrotum, and perineal area before cleaning the rectal area, going from cleanest to most soiled. The facility policy Perineal Care dated 6/21, indicated perineal care for men should begin with the penis, scrotum, and perineal area, followed by cleaning of the rectal area.	F 690		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 6, 2021

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

Re: State Nursing Home Licensing Orders
Event ID: KTGE11

Dear Administrator:

The above facility was surveyed on June 9, 2021 through June 14, 2021 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00189	A. BUILDING: _____ B. WING _____	C 06/14/2021

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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 6/9/21, 6/10/11, 6/11/21 and 6/14/21, 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

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H5556053C (MN00058102, MN00057840, MN00057892, MN00057906) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). at F550 and F690. H5556054C (MN00058416) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556055C (MN00073568) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556056C (MN00072937) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556057C (MN00072348) with licensing orders issued at (144,651 Subp 5, 4658.1415 Subp 4, and 4658.0525 Subp 5). H5556058C (MN00071877) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556059C (MN00071807) with licensing orders issued at (4658.0525 Subp 5). H5556060C (MN00071440) with licensing orders issued at (4658.1415 Subp 4). H5556061C (MN00059285) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556062C (MN00064121) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556063C (MN00071352) with licensing orders issued at (144,651 Subp 5, 4658.1415 Subp 4, and 4658.0525 Subp 5). H5556064C (MN00071195) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5).	2 000		

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2 000	Continued From page 2 H5556065C (MN00063570) with licensing orders issued at (144,651 Subp 5 and 144.651 Subp 20). H5556067C (MN00061945) with licensing orders issued at (144,651 Subp 5 and 4658.1415 Subp 4). H5556068C (MN00061908) with licensing orders issued at (144,651 Subp 5). H5556070C (MN00060561) with licensing orders issued at (144,651 Subp 5). H5556071C (MN00058665) with licensing orders issued at (144,651 Subp 5 and 4658.0525 Subp 5). H5556066C (MN00063317) with no licensing order issued. H5556069C (MN00061766) with no licensing order issued. H5556072C (MN00073783) with no licensing order issued. 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/regulatio	2 000		

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2 000	Continued From page 3 n/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents.	2 840		8/6/21

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2 840	Continued From page 4 Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate incontinent care for 1 of 3 residents (R6) reviewed for incontinence care. Findings include: During continuous observation on 6/10/21, at 8:38 a.m. through 8:55 a.m. registered nurse (RN)-B assisted R6 to the bathroom where she	2 840	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any	

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2 840	Continued From page 5 removed soiled brief and sweatpants. RN-B asked R6 to sit on the closed toilet seat cover so she could get the nurse practitioner (NP) to inspect his rectal area and he asked her to place a towel on the seat first. RN-B returned and stated the NP was busy so she would clean R6 and not place any barrier cream or dressings. R6 stated he needed to be wet wiped and cleaned. RN-B stated she wanted to put his Lidocaine patches on first and proceeded to apply one Lidocaine patch on each upper gluteal area. R6 stated that was not where his pain was, it was where he sat. After the patches were in place, RN-B assisted R6 to standing where she performed peri care with wet wipes. She cleaned his gluteal areas under the patches, then his rectal area, using an up and down motion in the rectal area. RN-B then cleaned his front, cleaning under his scrotum first and then his penis. R6's admission Minimum Data Set (MDS) dated 6/8/21, identified R6 had intact cognition. The MDS also indicated R6 was occasional incontinent of urine and required extensive assistance of one staff for toileting and transfers. R6's diagnosis list dated 5/6/21, indicated R6 had diagnoses of chronic low back pain, left hip pain, and spinal stenosis in the lower back. R6's care plan dated 6/2/21, indicated R6 wanted to be clean and well-dressed every day, requiring assistance of one with hygiene. The care plan also indicated R6 was incontinent of urine but was not on a toileting schedule; and he could ask for assistance. R6's Bowel, Bladder, and Skin Risk Summary and Analysis note dated 6/3/21, indicated R6 did not use an incontinent product was continent of	2 840	appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate Corrective Action: Perineal Care policy/procedure was reviewed by the Clinical and Care Center Administrators. RN-B was provided with coaching per progressive discipline policy and was reeducated on the perineal care policy/procedure. Corrective Action as it Applies to Other Residents: All nursing staff were reeducated on the perineal care policy/procedure. Microlearning education on □Understanding Urinary Tract Infections□ was initiated for all nursing staff. Microlearning education on □Appropriate Treatment for Urinary Tract Infections□ was also implemented for nurses. Reoccurrence will be Prevented By: Clinical Administrator, Clinical Coordinator, Infection Control and Prevention Specialist, or designee will complete random Perineal care audits on 10% of residents weekly on each household for 12 weeks. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits	

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2 840	Continued From page 6 urine, could identify the need to urinate, and could use the call light to request assistance. R6's Wound Assement note dated 6/8/21, indicated R6 had moisture associated skin damage (MASD) on his coccyx. R6's PN dated 6/11/21, indicated R6 had urge bladder incontinence (sudden intense urge to urinate followed by involuntary release of urine). R6's PN dated 6/15/21 indicated R6 could make his needs know, used a call light for help, and was continent of bowel and bladder. During an interview on 6/10/21, at 8:55 a.m. R6 stated he got frustrated at times because they did not keep him clean and dry. He stated they would try, but sometimes they "just want to get things done." R6 also stated he did not normally use an incontinence brief, they started when he was admitted to the facility because sometimes, he could not hold it and he would wet himself. During an interview on 6/10/21, at 8:57 a.m. RN-B stated she placed the Lidocaine patch before cleaning R6's gluteal area because he was in pain, and she wanted to help. RN-B verified perineal care on a male should begin with his genitals, cleaning from cleanest area first moving to the less clean area, and cleaning from front to back. RN-B stated was not sure why she cleaned his rectal area first. During an interview on 6/14/21, at 3:08 p.m. the director of nursing (DON) stated her expectation was staff would perform peri care prior to placing any patches or dressings on a resident. She also stated her expectation was staff would follow the Perineal Care Policy washing the penis, scrotum,	2 840	Date certain: 08/06/2021	

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2 840	Continued From page 7 and perineal area before cleaning the rectal area, going from cleanest to most soiled. The facility policy Perineal Care dated 6/21, indicated perineal care for men should begin with the penis, scrotum, and perineal area, followed by cleaning of the rectal area. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with incontinence care, to assure they are receiving scheduled checks for soiled clothing/beds and prompt changing of soiled clothing and bed linens. The director of nursing or designee, could conduct random audits of residents with incontinence care to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to keep the resident bathroom clean for 1 of 3 residents (R1) reviewed for a clean, homelike environment.	21695	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written	8/6/21

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21695	Continued From page 8 Findings include: R1's admission Minimum Data Set (MDS) dated 6/7/20, identified R1 had severe cognitive impairment and diagnoses which included frequent urinary tract infections (UTI), anxiety, metabolic encephalopathy, major depression, and chronic kidney disease. The MDS also indicated R1 was always incontinent of urine and frequently incontinent of feces and required extensive assistance with toileting and transfers. R1's care plan dated 4/12/21, indicated R1 had an activities of daily living (ADL) deficit and recurrent C-Diff infections (bacterial infection that causes diarrhea) but lacked interventions to maintain a clean, homelike environment. The Facility Cleaning Audit dated 4/29/21, indicated R1's room was found with dirty towels on the floor by shower and the handrails by R1's toilet had stool on it. During an observation on 6/9/21, at 9:40 a.m. housekeeper (HKP)-A was observed cleaning R1's room. During an observation on 6/9/21, at 12:01 p.m. R1's bathroom was observed with multiple areas of dried feces on the handles of the toilet seat riser, dried feces splattered on the right side of the wall when facing away from the toilet, and dried feces on the wall behind the toilet. The floor at the base of the toilet was observed to have a 1/4 inch of dark brown feces all the way around the toilet. Across from the shower just below the towel bar a roughly two-inch dried white spot of toothpaste was observed on the wall. Also observed in the bathroom, stacked between other items, was a pillow with a roughly 12-inch circular	21695	responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F584 Safe/Clean/Comfortable/Homelike Environment Immediate Corrective Action: R1□s bathroom was cleaned. Full time housekeeper was provided with coaching per progressive discipline policy regarding expectations and responsibilities for bathroom cleanliness. Corrective Action as it Applies to Other Residents: Deep cleaning policy was reviewed by the Clinical and Care Center Administrators, Housekeeping supervisor, and Environmental Services Director. Facility housekeeping staff have been reeducated on the deep cleaning policy and a deep cleaning checklist was initiated to ensure all areas have been cleaned. Environmental Services Director has put together binders for each household which will include the monthly deep clean policy, schedules, checklist, and audits. All Care Center nursing staff have been reeducated on their role in maintaining resident room and resident bathroom cleanliness.	

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21695	Continued From page 9 brown spot. During an interview on 6/9/21, at 11:44 a.m. family member (FM)-A stated R1's room was not cleaned like it should; "it was like the housekeeping staff are not even coming in sometimes." FM-A stated the bathroom was the worst part with the splattered spots of feces on the wall, toilet, around the toilet; dried toothpaste one the wall; and a pillow with a large brown stain on it, just stacked next to the shower for months. FM-A stated R1 was prone to urinary tract infections, and she needed to have a clean environment. FM-A further stated some of these areas have been dirty for four months. During an interview on 6/9/21, at 1:30 p.m. licensed practical nurse (LPN)-A indicated housekeeping was responsible for cleaning toilet seat risers, walls, and floors in bathrooms. LPN-1 confirmed R1's bathroom wall had a two-inch round spot of dried toothpaste on the wall. LPN-A also verified their appeared to be feces around the base of toilet floor, on the wall, and on the toilet seat riser. LPN-A also verified a soiled pillow, stained light brown about 12 inches in a circular pattern but stated it could be from washing R1's hair. During an interview on 6/9/21, at 2:12 p.m. registered nurse (RN)- F stated housekeeping was responsible for cleaning the residents' room, but if a resident had loose stool, as R1 often did, it should be addressed by the aides or nursing staff immediately and not left for housekeeping. During an interview on 6/10/21, at 8:30 a.m. the director of housekeeping (DH) stated deep cleaning was scheduled and done once a month for each resident and once a day housekeepers	21695	Reoccurrence will be Prevented By: Environmental Services Director, Housekeeping supervisor or designee will be completing housekeeping audits on 10% of resident rooms weekly for 12 weeks. Audits will address room cleanliness, completion of checklist and compliance with the deep clean schedule. Deep clean schedules will be audited by housekeeping supervisors on a weekly basis and kept with both Housekeeping supervisors to ensure completion of deep cleaning. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits. Date certain: 08/06/2021	

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would clean the bathroom, the floors, and remove the garbage. The DH stated the expectation was for the room to be deep cleaned and then signed off after the work was completed. The DH reviewed the calendar of deep cleaning scheduled for 6/10/21, which indicated R1's room was scheduled for deep cleaning, but it was already signed off the work was completed. After inspection of R1's room, the DH confirmed there were spots of dried feces on the wall behind the toilet, the bars, and the back area of the toilet seat riser, and on the floor around the toilet. The DH stated when bathrooms got dirty it should be cleaned for the health and safety of the resident.

During an interview on 6/14/21, at 3:08 p.m. the director of nursing (DON) stated all staff were responsible for keeping all areas cleaned for the residents to make it a homelike environment. The DON further stated cross contamination could occur if feces was on the handles of the toilet seat riser where staff could touch and then touch the resident during cares. The DON stated her expectation was staff would not wait for housekeeping but clean the feces up prior to housekeeping coming in the next day.

The facility's Policy Deep Cleaning Resident Rooms dated 3/15/12, indicated resident's rooms would be deep cleaned on a scheduled basis to ensure rooms are cleaned and sanitized properly.

The facility's PHS Housekeeping policy dated 10/1/18, directed staff to perform cleaning responsibilities above and beyond the daily minimum levels to prevent cross contamination.

SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or

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21695	Continued From page 11 designee could ensure random audits to accurately reflect ongoing surveillence for cleanliness of bathrooms. The facility could educate nursing staff on performing and reporting environmental rounds/audits periodically to ensure cleanliess bathrooms is met. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignified clothing for 1 of 3 resident (R6) who expressed they would prefer not to wear soiled clothing. Findings include: During continuous observation on 6/10/21, at 8:38 a.m. through 8:55 a.m. registered nurse (RN)-B entered R6's room with morning medications; R6 stated his "butt is sore." RN-B instructed R6 to turn on his side so she could place Lidocaine patches. As R6 turned on his left	21805	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently	8/6/21

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21805	Continued From page 12 side, he grabbed the top of the adult incontinence brief he was wearing, pulled on it, and emphatically stated, "this is wet. I want to go to the bathroom." RN-B suggested he take his medications first and R6 stated, "I'm wet!" RN-B then assisted R6 to the bathroom where she removed R6's soiled brief and sweatpants. After RN-B cleaned R6 and placed a new brief, she redressed R6 in the soiled sweatpants. R6 stated, "they're damp." RN-B stated there were no other clothes and R6 said it was okay because he didn't want to just wear a brief. R6's care plan dated 6/2/21, indicated R6 wanted to be clean and well-dressed every day, requiring assistance of one with hygiene. The care plan also indicated R6 was incontinent of urine but was not on a toileting schedule; it indicated he could ask for assistance. During an interview on 6/10/21, at 8:55 a.m. R6 stated he did not usually wear incontinence briefs but sometimes he can't just hold it and staff are slow to answer call lights; they started using the product on him shortly after he arrived at the facility but doesn't remember which day. R6 stated his preference was to go to the bathroom rather than "wear a diaper like a baby." R6 wasn't sure if he had any clean, dry pants and stated his preference was not to put soiled pants back on if he did have clean pants. During an interview on 6/10/21, at 8:57 a.m. RN-B stated she did not know if R6 had any clean pants as this was the second time, she provided care for him; she put on the damp pants because she thought he would want to have pants on. During an interview on 6/14/21, at 3:08 p.m. the director of nursing (DON) stated her expectation	21805	imposed, by timely appeal to the Departmental Appeals Board. F550 Resident Rights/Exercise of Rights Immediate Corrective Action: RN-B received coaching and re-education on resident rights and the perineal care policy/procedure. Corrective Action as it Applies to Other Residents: The perineal care policy/procedure was reviewed by Clinical and Care Center Administrator. All Care Center nursing staff were reeducated on resident rights as it relates to dignity and the Perineal care policy/procedure. Reoccurrence will be Prevented By: IDT will complete weekly perineal care audits as well as weekly resident dignity audits for 12 weeks. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits. Date certain: 08/06/2021	

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21805	Continued From page 13 was staff would not dress residents in soiled clothing; rather, would dress residents in clean clothing. The facility's Perineal Care Policy dated June 2021, indicated staff were to remove and dispose of wet/soiled articles in an appropriate container after removing from a resident. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained by promptly attending to toileting needs to prevent residents from sitting in soiled clothing for extended periods of time. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as	21880		8/6/21

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21880	Continued From page 14 well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow up and provide written responses to resident concerns about responsiveness to call lights for 6 of 6 residents (R1, R7, R8, R9, R10, and R11) reviewed for grievances.	21880	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission	

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21880	Continued From page 15 Findings include: NO WRITTEN RESPONSE TO GRIEVANCE WHEN REQUESTED R1's quarterly Minimum Data Set (MDS) dated 4/7/21, indicated R1 had a Brief Interview of Mental Status (BIMS) score of 5, indicating severe cognitive impairment, and diagnoses of scoliosis, anxiety, and depression. The MDS also indicated R1 was always incontinent of urine and frequently incontinent of feces and required extensive assistance with toileting and bed mobility. R1's quality concern form dated 4/15/21, indicated R1 filed a written complaint, dated 4/14/21, in which she complained about her bed being made with "wet and soiled linens." In the written complaint, R1 wrote, "As I have requested previously, I am asking that I receive any response to this in a written form." The form indicated R1 was contacted on 4/14/21, for an update but there was no written response nor indication of what the resident was told in response to her grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file. The administrator stated grievances did not have to be responded to in writing. R1's quality concern form dated 4/21/21, indicated R1's daughter filed a verbal grievance about dried feces found on the soaker pad and fitted sheet. The section indicating follow-up was left blank. The administrator stated he was sure this was followed up on but was unsure why that section was blank. The administrator verified his	21880	of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F585 Grievances Immediate Corrective Action: Quality Concern/Grievance process was reviewed by the Clinical and Care Center Administrators and updated to reflect the contact information of the grievance officer. Updated process was posted visibly at all nursing stations. Grievances cited for R1, R7, R8, R9, R10 and R11 were reviewed to ensure written follow up was provided to the resident or family member that completed the grievance form. Corrective Action as it Applies to Other Residents: SW-A received coaching per progressive discipline policy regarding informing residents of the Quality concern/Grievance process upon admission. The Quality concern/Grievance process has been added to all admission packets to ensure residents are aware of their rights to file a grievance. All departments were reeducated on the Quality concern/Grievance process. Quality concerns/Grievances will be reviewed daily with the IDT to ensure concerns are addressed promptly, are	

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21880	Continued From page 16 signature on the form, indicating he reviewed the form. There was no written response to the grievance. INCOMPLETE WRITTEN RESPONSE TO GRIEVANCE R11's admission MDS dated 4/28/21, indicated R11 had a BIMS score of 7, indicating severe cognitive impairment and diagnoses of Alzheimer's disease and malnutrition. The MDS also indicated R11 was frequently incontinent of urine and required extensive assistance with toileting and bed mobility. R11's quality concern form dated 5/27/21, indicated R11 reported three staff members responded to her call light but her needs were not met for over 30 minutes and the nursing assistant (NA) informed her she could not assist because it was change of shift. The clinical coordinator's written response to F11's grievance lacked all components required for a written response to a grievance; missing were a summary statement of the grievance, steps taken to investigate the grievance, and how the grievance was resolved. LACK OF WRITTEN RESPONSES TO GRIEVANCES R7's quarterly MDS dated 12/29/20, indicated R7 had a BIMS score of 10, indicating moderate cognitive impairment, and diagnoses of debilitating heart failure, kidney disease, and dementia. The MDS also indicated R7 was frequently incontinent of bowel and urine and required extensive assistance with toileting and bed mobility. R7's quality concern form dated 2/2/21, indicated	21880	responded to in writing, and include all components of a written response. Concerns/Grievances submitted on the weekend will be discussed on Monday. Reoccurrence will be Prevented By: Audits will be completed on every grievance submitted for 12 weeks to ensure documentation of written follow up is provided to the person who initiated the process. Audit trends will be reported by the Clinical or Care Center Administrator to the Quality Assurance committee to ensure compliance and determine ongoing need for audits Date certain: 08/06/2021	

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R7 complained about the call light being on for six hours; it was answered several times, but no one helped her with blankets or toileting. The form indicated R7 was contacted on 2/2/21, for an update but there was no written response nor indication of what the resident was told in response to her grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file.

R8's admission MDS dated 2/24/21, indicated R8 had a BIMS score of 9, indicating severe cognitive impairment, and medical diagnoses of fractured left fibula, pneumonia, and dementia. The MDS also indicated R8 was frequently incontinent of urine and feces and required extensive assistance with toileting and bed mobility.

R8's quality concern form dated 3/29/21, indicated R8's family member (FM)-C had numerous concerns including long call light wait times (on 3/27/21, and again on 3/29/21), using a wastebasket to prop up R8's foot during wound care, unfriendly staff, lack of updating of the care board, and a nurse hanging up on the daughter when she called the facility on 3/5/21. The form indicated R8's FM-C was contacted on 3/29/21, for an update but there was no written response nor indication of what the resident was told in response to the grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file.

R9's admission MDS dated 5/18/21, indicated R9 had a BIMS score of 15, indicating intact cognitive and diagnoses of fractured hip, pneumonia, and heart failure. The MDS also

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21880	Continued From page 18 indicated R9 was frequently incontinent of urine and feces and required extensive assistance with toileting and bed mobility. R9's quality concern form dated 5/11/21, indicated R9, FM-M, and FM-B were concerned about R9's call light wait times (up to an hour) since 5/3/21 and when NA responded, NA told R9 to "urinate in his brief." The form indicated R9, FM-A, and FM-B were contacted on 5/11/21 for an update but there was no written response nor indication of what the resident was told in response to his grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file. R10's admission MDS dated 4/13/21, indicated R10 had a BIMS score of 15, indicating intent cognitive and medical diagnoses of sacral (lower back/tailbone) fracture. The MDS also indicated R10 was frequently incontinent of urine and required extensive assistance with toileting and bed mobility. R10's quality concern form, dated 5/24/21, indicated R10 reported a female NA told her she used the call light too much. The form indicated R10 was contacted on 5/24/21, for an update but there was no written response nor indication of what the resident was told in response to her grievance. The administrator stated a verbal response was provided but could not say what the verbal response was as there were no written notes in the grievance file. During an interview on 6/10/11/21, in the afternoon, the administrator stated at some point they stopped taking R1's grievances and just	21880		

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started making a list of complaints. The administrator did not recall how those complaints were processed or resolved.

During an interview on 6/14/21, at 10:42 a.m. social worker (SW)-A stated she did not discuss the grievance process when residents were admitted to the facility because the facility did not want them to think the facility was a bad one because they had grievances. SW-A stated if a complaint could not be resolved, she would then inform them they could complete a Quality Concern Form and she would assist them with the form. SW-A stated R1's family member (FM)-A filed so many complaints, they just started keeping a list rather than treat each one as a grievance.

During an interview on 6/14/21, at 5:53 p.m. the administrator stated he was the Grievance Officer. The administrator was not sure where he was listed as the grievance officer to the residents and verified the Quality Concern Form did not identify him as the Grievance Officer or provide any contact information for the Grievance Officer. The administrator stated verbal grievances were not responded to in writing, but if a resident requested, they would get a response in writing; if an e-mail, they would respond via e-mail. The administrator verified only R11's grievance had a written response and R1's 4/21/21, form did not indicate a follow-up. The administrator verified R1's 4/15/21, form, and R7, R8, R9, and R10's forms indicated follow-up was completed with the resident, but he did not know what the follow-up entailed; he verified he signed each Quality Concern Form indicating he had reviewed handling of the grievance. The administrator stated the facility was working on call light response times and had a plan for

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reducing wait times from six minutes to five minutes. The administrator could not answer how they were working to reduce the time it took to meet the residents' toileting needs after the call light was answered. The administrator stated it was his expectation the social workers would inform the residents of their rights to file a grievance upon admission, assist residents with writing grievances, and have a grievance form for each grievance.

The facility's grievance policy dated September 2020, indicated the administrator was the Grievance Officer but lacked the administrator's name and contact information in the policy or on the Quality Concern Form, which was the form used for grievances. The policy indicated all grievances would be addressed within five working days and action items would be communicated to the individual filing the grievance. The policy lacked any actions related to a written response to a grievance or what a written response to a grievance should contain.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents complaints and grievances are being addressed promptly and responded to in writing included all components of a written decision by the Grievace official. The facility could update policies and procedures and audit periodically to ensure written responses to resident(s) complaints and grievances meet the regulatory requirements for a written response. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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
21880	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty One (21) days	21880		