Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 19, 2024

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

RE: CCN: 245572
Cycle Start Date: July 24, 2024

Dear Administrator:

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

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 19, 2024

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

Re: Reinspection Results
Event ID: 6IXW12

Dear Administrator:

On September 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2024

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

RE: CCN: 245572
Cycle Start Date: July 24, 2024

Dear Administrator:

On July 24, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 24, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 24, 2025 (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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
August 13, 2024

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

Re: State Nursing Home Licensing Orders
Event ID: 6IXW11

Dear Administrator:

The above facility was surveyed on July 23, 2024 through July 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

(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 7/23/24 and 7/24/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H55724696C (MN104228), H55724462C (MN103949) and H55724359C (MN103927) with deficiencies cited at F657, F686 and F690. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		8/30/24

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

Electronically Signed | 08/23/2024

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

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F 657	Continued From page 1 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan for 1 of 1 resident (R1) who had a change with activities of daily living (ADL's). Findings include: R1's admission minimum data set (MDS) dated 4/15/24, identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to substantial assist with adl's. No signs or symptoms of a possible swallowing disorder. R1's current weight was 178 pounds. R1's significant change MDS, dated 6/18/24, identified R1 required partial to substantial assist with adl's. Further identified R1 had coughing or choking during meals or when swallowing medications. R1's weight was 160 pounds.	F 657	How will the facility accomplish the corrective action for individual affected by deficiency? Care plan reviewed and updated to reflect the appropriate skill level for ADl's. What other residents in the facility have the potential to be affected by this deficiency? All residents have the potential to e affected by this deficiency. How will this facility protect other individuals who may be affected or in similar situations? Care plans to be reviewed and revised on all residents ADL's to ensure reflection of appropriate skill level. What systemic changes will ensure that the deficient practice will not recur? Staff education on care plans. Care plans reviewed and revised with changes in condition, at morning meeting by clinical staff. Care plan policy reviewed and	

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F 657	Continued From page 2 R1's Speech Language Pathologist (SLP) communication form to dietary and nursing, dated 6/19/24, identified R1 will need staff assistance with feeding at every meal, will also need frequent cues to sit up, as well as being fed. R1's progress note dated 6/19/24, identified R1 needed staff assistance with feeding at every meal, will need frequent cues to sit up, as well as being fed, staff updated. R1's care plan edited 7/3/24, identified a problem with ADL dependencies; requires assist with adl's related to advanced Alzheimer's disease with significant deficits and inability to care for self. Goal: 6. Eating: R1 will continue to participate in eating through the review date. Approach dated 4/26/24, R1 participated in eating by feeding self after set-up. Does need occasional cueing as needed during eating and drinking. Provide set up to extensive assist at night and as needed. R1's care plan did not identify problems with swallowing or choking on foods or medications nor was it revised to include the SLP orders that R1 needed staff assistance with feeding at every meal, will also need frequent cues to sit up, as well as being fed. During an interview on 7/24/24 at 12:34 p.m. licensed practical nurse (LPN)-A stated, we try to feed R1 if we can, he doesn't make as big of a mess on himself and eats better. R1 can do it, it's just better if we do it. During an interview on 7/24/24 at 12:34 p.m. nursing assistant (NA)-F stated, R1 can feed himself, but R1 eats better when we feed him so we feed him if we can.	F 657	updated. How will the facility monitor its corrective actions/performance? Education retention will be monitored: Weekly x 4 days, then weekly x 3 days, then weekly x 2 days. Care plan changes will be monitored: Weekly x 4 days, then weekly x 3 days, then weekly x 2 days. Person Responsible: Director of Nursing	

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F 657	Continued From page 3 During an interview on 7/24/24 at 12:44 p.m., DON stated the care plan was not revised to include the speech order from 6/19/24. DON further stated R1 had lost weight, and the dietician had followed up with supplements and a sandwich to given at bed time. In addition, the aides should be documenting how much R1 had eaten with each meal and what level of assist was needed. The nurse working the floor would be responsible to update the care plan and revise when necessary. Facility policy titled, "Care plan policy," dated 8/23, the policy identified to assure the care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the residents stay. To assure that the resident and/or their representative, along with the entire care team is involved in the care planning process. To assure the care is planned to attain or maintain the resident's highest physical, mental ad psychosocial well-being ...V. Status Change Review a. held as necessary to revise the plan of care, b. The observed change and/or current need is summarized in writing in the medical record and a new plan of approach and goal is developed. c. all participants in the meeting sign their name to indicate the review has occurred. D. if a significant change has occurred, a new MDS will be completed by the assigned disciplines.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		8/30/24

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F 686	Continued From page 4 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess, monitor, develop and implement person centered interventions to prevent a pressure ulcer for 1 of 3 residents (R1) reviewed who entered the facility without a pressure ulcer. Findings include: R1's Braden Scale Comprehensive Risk Assessment dated 4/8/24, identified R1 to score a 20 indicating no risk of pressure ulcers. R1 did not use a wheelchair and ambulated without an assistive device. Licensed nurse to assess skin weekly and as needed, will initiate plan of care to put a pressure reducing device for R1's bed. R1's admission minimum data set (MDS) dated 4/15/24, identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene, and was frequently incontinent bladder and always continent of bowel. R1 was identified at risk for	F 686	How will the facility accomplish corrective action for the affected individuals? Resident R1 wound resolved. Care plan updated. What other residents in the facility have the potential to be affected by this deficiency? All residents with a BRADEN score of 18 or lower have the potential to be affected by this deficiency. How will this facility protect other individuals who may be affected or in similar situations? Person centered pressure ulcer interventions will be reviewed/initiated residents with BRADEN score of 18 or lower. What systemic changes will ensure that the deficient practice will not recur? Weekly wound rounds with assessment and measurements to existing wounds. New wounds will be reviewed at IDT meeting the day after wound is reported. Education to staff on pressure ulcer prevention. Policy reviewed and updated. How will the facility monitor its corrective actions/performance? Staff will be monitored for education retention. Three staff members: weekly x 4 times. Three	

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F 686	Continued From page 5 pressure ulcers with interventions of a pressure reducing device for bed and chair. No pressure ulcer was identified. R1's Braden Scale Comprehensive Risk Assessment dated 4/28/24, identified R1 to score a 17 indicating R1 was at risk for pressure ulcers. Interventions included a pressure reducing cushion in bed and a Roho cushion (a pressure relief cushion designed for wheelchairs that's made of flexible air cells connected by small channels) in wheelchair as R1 was now chairfast. R1's progress note dated 5/11/24, identified R1 had a wound which was possible shearing. R1's coccyx wound measured 8 centimeters (cm) x 1 cm. Left open to air and applied barrier cream, will monitor daily. R1's progress note dated 5/27/24, identified the nurse was called to the tub room, upon assessment R2 had sustained two pressure areas on coccyx. Mepilex border dressing (dressing used for exuding pressure ulcers, shields the wound and the silver helps kill bacteria) placed, director of nursing (DON), administrator, case manager and provider updated. Additional note indicated family was notified of pressure areas. R1's progress note dated 5/29/24, identified new orders received for Arginaid (nutritional support to help heal wounds) every day and provider agreed with Mepilex dressing to coccyx to change every 3 days and as needed. R1's progress note dated 5/30/24 identified R1's skin was warm and dry, coccyx area healing, no other skin breakdown noted.	F 686	staff members: weekly x 3 times. Three staff members: weekly x 2 times. Wound rounds will be monitored for progress. Three wounds: weekly x 4 times. Three wounds: weekly x 3 times. Three wounds: weekly x 2 times. Audits to be reviewed with medical director at QUAPI meeting to determine if continuation of audits are needed. Person responsible: Director of Nursing	

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F 686	Continued From page 6 R1's May 2024, treatment administration record (TAR) dated 5/27/24, identified the physician order to check Mepilex dressing every shift on coccyx and replace as needed. On 5/30/24, identified the physician order to change Mepilex dressing every 3 days and as needed. No treatment noted to coccyx area from 5/11/24 to 5/27/24. R1's bath sheet dated 6/6/24, identified R1's treatment to pressure ulcer to coccyx was completed. R1's bath sheet dated 6/13/24, identified R1's pressure ulcer to coccyx was healed but will continue to treat as a preventative. R1's Braden skin risk assessment dated 6/18/24, identified R1 to score a 15 indicating at risk for pressure ulcers. R1 had a pressure ulcer to coccyx, but this has healed see bath sheet 6/13/24, has been using tilt in space wheelchair (helps a person to redistribute pressure), had been incontinent of bowel and bladder. R1's skin observed twice a day with cares and changes are reported to licensed nurse, will have licensed nurse inspect skin weekly and as needed. Will continue with current care plan. R1's significant change MDS, dated 6/18/24, identified R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene. Further identified R1 was always incontinent bladder and frequently incontinent of bowel. R1 was identified at risk for pressure ulcers with interventions of a pressure reducing device for bed and chair and application of nonsurgical dressings other than to feet. No	F 686		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

(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 686	Continued From page 7 turning and repositioning program and no pressure ulcer identified. R1's care plan edited 7/3/24, identified a problem that R1 was at risk for skin breakdown related to weakness with inability to reposition self at times, arthritis, gout, coronary artery disease (CAD), peripheral vascular disease (PVD) of bilateral lower extremities and Alzheimer's disease with severe cognitive deficits. Goal: R1 skin will remain intact throughout review date. Approaches: On 4/26/24, turn and reposition R1 in bed (rotate between sides and back) and wheelchair (offload stand if able) per adl section of the care plan. ADL section identified to reposition R1 every 3 hours as needed. On 4/30/24, assess R1 for presence of risk factors, treat, reduce, eliminate risk factors to extent possible. Keep skin clean and dry as possible, minimize skin exposure to moisture, toilet and provide incontinence cares per adl section of the care plan. R1's bath sheet dated 7/13/24, identified R1's coccyx looked fragile in appearance, treatment done per order. Even though R1's Braden scale risk assessments were performed R1's record did not show a causal analysis for the pressure ulcer sustained to coccyx area. Further, it was not evident R1's care plan identified that R1 developed a pressure ulcer or was revised to prevent additional pressure ulcers. In addition, R1's record lacked comprehensive pressure ulcer assessments when R1 developed a pressure ulcer to the coccyx to determine if the treatments that were completed helped heal the pressure ulcer. Record lacked a tissue tolerance test (a pressure	F 686		

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	245572	A. BUILDING _____ B. WING _____	C 07/24/2024

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F 686	Continued From page 8 test to determine how often a resident should be repositioned to prevent pressure ulcers), lacked daily monitoring of R1's skin and lacked weekly comprehensive wound assessments of R1's pressure ulcer to the coccyx. It lacked staging, characteristics, signs and symptoms of infection, and pain with dressing changes. R1's July 2024, treatment administration record (TAR) identified the physician order to change Mepilex dressing every 3 days and as needed. On 7/20/24 and 7/23/24 it was documented as completed. During an observation and interview on 7/24/24, at 1:35 p.m. nursing assistant (NA)-E and licensed practical nurse (LPN)-A were observed to toilet R1, Mepilex on coccyx was dated 7/19/24 (indicating the dressing was not changed in accordance with physician order), R1 was placed in the recliner after being toileted. During an interview on 7/24/24 at 1:45 p.m. director of nursing (DON) stated typically with any resident that has a wound they would go on the wound list to be seen by the wound clinic, they are the only ones who do weekly measurements. DON indicated R1 was not on the wound clinic list and was unable to articulate why R1 was never on the list. R1 did have a pressure ulcer to the coccyx but understood it had since healed up and a Mepilex was used for protection. DON stated pressure ulcers were an area that need improvement and "are on our radar." Facility policy titled, "Skin Care," revised March 2017, identified each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and	F 686		

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F 686	Continued From page 9 psychosocial well-being, in accordance with the comprehensive assessment and plan of care related to skin care; a person who enters the facility without pressure ulcers does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and the resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing ...c. interventions to ...g. provide an individualized repositioning program, h. provides daily monitoring of skin condition with at least weekly documentation ...j. for existing ulcers: 1. Monitor the ulcers characteristics, 2. Monitor the progress toward healing and potential complications, 3. Assess, treat, and monitor pain if present, 4. Monitor dressing and treatments ...	F 686		
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	F 690		8/30/24

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F 690	Continued From page 10 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 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 develop an individualized toileting program to maintain or improve bowel/bladder continence resulting in a decline in continence for 1 of 1 residents (R1) reviewed for incontinence. Findings include: R1's admission minimum data set (MDS) dated 4/15/24, identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene, and was frequently incontinent bladder and always continent of bowel. R1's Bowel and Bladder assessment initiated on	F 690	How will the facility accomplish the corrective action for the individual affected by deficiency? Bowel and bladder assessment completed. Care plan updated. What other residents in the facility have the potential to be affected by this deficiency? All residents have the potential to be affected by this deficiency. How will this facility protect other individuals who may be affected or in similar situations? All residents with incontinence will be monitored to ensure care services are implemented to maintain or prevent incontinence. What systemic changes will ensure that the deficient practice will not recur? Education to staff of bowel and bladder monitoring. RN will review bowel and bladder assessments of new residents and their need of bladder training	

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F 690	Continued From page 11 4/15/24 and was completed on 4/16/24 identified R1 had a trial of a toileting program since urinary incontinence was noted in this facility. R1's toileting program response was unable to determine or trial in progress, R1 was frequently incontinent of bladder and always continent of bowel. R1 required limited assistance with toileting and was usually aware of toileting needs. R1 was identified to have urine leakage without sensation of urine loss, nocturia (greater than 2 times a night) and enuresis (bed wetting). Further identified R1 to have mixed incontinence, had mobility/manual dexterity impairments, lack of ability to get to the toilet or commode/bedpan without staff assist, recognized the appropriate time/place to void and defecate, able to feel the urge to void and was able to feel sensation for bowel movement. R1 appeared to be a good candidate for bowel/bladder retraining program, care plan will be initiated and will have increased episodes of bladder continence with initiation of toileting program and remain always continent of bowels through the review date. R1's care plan will include to toilet R1 prior to breakfast, upon arising from afternoon nap and at bedtime to try and prevent episodes of bladder incontinence. R1 had always been continent of bowels. Bowel pattern has varied between every other day and every third day since admission. Staff to assist R1 as needed or at times R1 will take himself. R1 had significant dementia and will not always communicate toileting needs and will wear a pull-up daily secondary to bladder incontinence. R1's provider orders dated 4/15/24 identified R1 should be toileted in AM prior to breakfast, upon arising from afternoon nap, and at bedtime to try and prevent some episodes of bladder incontinence. R1's record did not include a	F 690	program. Care plans updated as needed. Bowel and bladder policy reviewed and updated. How will the facility monitor its corrective actions/performance? Education retention will be monitored:3 staff members: weekly x 4 days then, weekly x 3 days, then weekly x 2 days. Bowel and bladder assessment on new residents will be monitored weekly x 4 days, then weekly x 3 days, then weekly 2 x days. Audits will be reviewed at QUAPI meeting to determine if continued monitoring is required. Person Responsible: Director of Nursing Update: Please review attachment labeled R1 and attachment labeled BnB Education. R1 Bowel and bladder were assessed, care plan were reviewed and updated. Education was giving to staff on the purpose of a bowel and bladder assessment. Goal is for the resident to maintain their highest practicable level of continence. 7 day bowel and bladder monitoring sheet will be utilized. Staff will toilet residents per their care plan and as needed. Staff to notify charge nurse with any changes noted with bowel and bladders. Charge nurse will notify residents" PC with any changes in condition. Auditing and monitoring residents" care plans for accuracy.	

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F 690	Continued From page 12 voiding diary and/or an assessment in order to identify R1's baseline or normal toileting routine in which the aforementioned toileting schedule was developed and implemented. R1's care conference note dated 4/26/24, identified R1 was frequently incontinent of bladder and always continent of bowel. R1's Bowel and Bladder assessment dated 6/18/24, identified R1 had a trial of a toileting program with no noted improvement. R1 was always incontinent of bladder and always incontinent of bowel. No bowel toileting program being used to manage R1's incontinence. R1 required extensive assistance with toileting. R1 was identified to have urine leakage without sensation or urine loss, nocturia and enuresis. Further identified R1 to have mixed incontinence, had mobility/manual dexterity impairments, lack of ability to get to the toilet or commode/bedpan without staff assist, able to feel the urge to void and able to feel sensation for bowel movement. R1 appeared to be a good candidate for bowel/bladder retraining program, continue to current care plan. R1's significant change MDS, dated 6/18/24, identified R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene. Further identified R1 was always incontinent bladder and frequently incontinent of bowel. Even though R1's bowel and bladder assessments and MDS assessments showed a decline in continence, R1's record did not show a causal analysis. Further, it was not evident R1's	F 690		

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F 690	Continued From page 13 toileting plan was revised to improve bowel and bladder incontinence and/or prevent decline. Additionally, the record did not indicate the physician was notified of R1's decrease in incontinence. R1's care plan edited 7/3/24, identified a problem with activities of daily living (ADL) dependencies, required assistance with adl's related to advanced Alzheimer's disease with significant memory deficits and inability to care for self. 7. Goal: toileting and continence, R1 will remain always continent of bowels and have decreased incontinence with current bladder retraining program through review date. Approaches: on 4/26/24, toileting plan to toilet R1 per schedule and if noted to be trying himself, R1 was frequently incontinent and required extensive assist of one staff with toileting, and on 4/30/24, R1 was always continent of bowel. R1's Point of Care history identified R1 was supposed to be toileted three times a day. The record reviewed between 5/24/24 to 7/24/24 showed R1 was not always toileted per the care plan. Specific examples between 7/1/24 to 7/24/24 included the following: 7/1/24: toileted x 1 7/2/24: toileted x 1 7/3/24: toileted x 2 7/4/24: toileted x 2 7/5/24: toileted x 1 7/6/24: toileted x 1 7/7/24: toileted x 2 7/8/24: toileted x 3 7/9/24: toileted x 2 7/10/24: toileted x 3 7/11/24: toileted x 1 7/12/24: toileted x 2	F 690		

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F 690	Continued From page 14 7/13/24: toileted x 2 7/14/24: toileted x 1 7/15/24: toileted x 1 7/16/24: toileted x 1 7/17/24: toileted x 2 7/18/24: toileted x 1 7/19/24: not toileted 7/20/24: toileted x 3 7/21/24: toileted x 3 7/22/24: toileted x 2 7/23/24: toileted x 3 7/24/24: toileted x 1 During an observation on 7/24/24 at 1:35 pm, R1 was toileted by staff and had a wet brief. During an interview on 7/24/24 at 1:35 p.m., nursing assistant (NA)-E stated R1 was last toileted at 11:00 am and R1 had voided. During an interview on 7/24/24 at 1:45 p.m., DON stated R1 had a decline in bowel and bladder incontinence, when R1 went from always continent of bowel and frequently incontinent of bladder to always incontinent of bowel and bladder. DON was unable to articulate a treatment and service plan to improve or maintain bowel and bladder. DON stated R1 should have been on a toileting plan to offer toileting every two hours not three times a day. Facility policy titled, "Bowel and Bladder Policy," revised 8/2023, indicated each resident receives the necessary care and service to attain or maintain the highest practicable level of bowel and bladder continence ...2. The comprehensive assessment results are used to develop a care plan addressing the individual needs of each resident. Care plan interventions are determined	F 690		

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F 690	Continued From page 15 with consideration of: a. the ability of the resident to make decisions and call for assistance to use the toilet. B. The presence of permanent physical impairment or disease which could prevent incontinence. C. Resident's desire to participate in bowel and bladder programing. D. current standards of practice in accordance with state and federal law. 3. Review of the comprehensive assessment and care plan will occur on at least a quarterly basis and more frequently if there is a change in residents condition ...	F 690		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/23/24 and 7/24/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55724696C (MN104228), H55724462C (MN103949) and H55724359C (MN103927) with a licensing order issued at 0900 and 0910. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess, monitor, develop and implement person centered interventions to prevent a pressure ulcer for 1 of 3 residents (R1) reviewed who entered the facility without a pressure ulcer. Findings include:	2 900	Corrected	8/21/24

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2 900	Continued From page 3 R1's Braden Scale Comprehensive Risk Assessment dated 4/8/24, identified R1 to score a 20 indicating no risk of pressure ulcers. R1 did not use a wheelchair and ambulated without an assistive device. Licensed nurse to assess skin weekly and as needed, will initiate plan of care to put a pressure reducing device for R1's bed. R1's admission minimum data set (MDS) dated 4/15/24, identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene, and was frequently incontinent bladder and always continent of bowel. R1 was identified at risk for pressure ulcers with interventions of a pressure reducing device for bed and chair. No pressure ulcer was identified. R1's Braden Scale Comprehensive Risk Assessment dated 4/28/24, identified R1 to score a 17 indicating R1 was at risk for pressure ulcers. Interventions included a pressure reducing cushion in bed and a Roho cushion (a pressure relief cushion designed for wheelchairs that's made of flexible air cells connected by small channels) in wheelchair as R1 was now chairfast. R1's progress note dated 5/11/24, identified R1 had a wound which was possible shearing. R1's coccyx wound measured 8 centimeters (cm) x 1 cm. Left open to air and applied barrier cream, will monitor daily. R1's progress note dated 5/27/24, identified the nurse was called to the tub room, upon assessment R2 had sustained two pressure	2 900		

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2 900	Continued From page 4 areas on coccyx. Mepilex border dressing (dressing used for exuding pressure ulcers, shields the wound and the silver helps kill bacteria) placed, director of nursing (DON), administrator, case manager and provider updated. Additional note indicated family was notified of pressure areas. R1's progress note dated 5/29/24, identified new orders received for Arginaid (nutritional support to help heal wounds) every day and provider agreed with Mepilex dressing to coccyx to change every 3 days and as needed. R1's progress note dated 5/30/24 identified R1's skin was warm and dry, coccyx area healing, no other skin breakdown noted. R1's May 2024, treatment administration record (TAR) dated 5/27/24, identified the physician order to check Mepilex dressing every shift on coccyx and replace as needed. On 5/30/24, identified the physician order to change Mepilex dressing every 3 days and as needed. No treatment noted to coccyx area from 5/11/24 to 5/27/24. R1's bath sheet dated 6/6/24, identified R1's treatment to pressure ulcer to coccyx was completed. R1's bath sheet dated 6/13/24, identified R1's pressure ulcer to coccyx was healed but will continue to treat as a preventative. R1's Braden skin risk assessment dated 6/18/24, identified R1 to score a 15 indicating at risk for pressure ulcers. R1 had a pressure ulcer to coccyx, but this has healed see bath sheet 6/13/24, has been using tilt in space wheelchair (helps a person to redistribute pressure), had	2 900		

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	00302	A. BUILDING: _____ B. WING _____	07/24/2024

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2 900	Continued From page 5 been incontinent of bowel and bladder. R1's skin observed twice a day with cares and changes are reported to licensed nurse, will have licensed nurse inspect skin weekly and as needed. Will continue with current care plan. R1's significant change MDS, dated 6/18/24, identified R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene. Further identified R1 was always incontinent bladder and frequently incontinent of bowel. R1 was identified at risk for pressure ulcers with interventions of a pressure reducing device for bed and chair and application of nonsurgical dressings other than to feet. No turning and repositioning program and no pressure ulcer identified. R1's care plan edited 7/3/24, identified a problem that R1 was at risk for skin breakdown related to weakness with inability to reposition self at times, arthritis, gout, coronary artery disease (CAD), peripheral vascular disease (PVD) of bilateral lower extremities and Alzheimer's disease with severe cognitive deficits. Goal: R1 skin will remain intact throughout review date. Approaches: On 4/26/24, turn and reposition R1 in bed (rotate between sides and back) and wheelchair (offload stand if able) per adl section of the care plan. ADL section identified to reposition R1 every 3 hours as needed. On 4/30/24, assess R1 for presence of risk factors, treat, reduce, eliminate risk factors to extent possible. Keep skin clean and dry as possible, minimize skin exposure to moisture, toilet and provide incontinence cares per adl section of the care plan. R1's bath sheet dated 7/13/24, identified R1's	2 900		

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2 900	Continued From page 6 coccyx looked fragile in appearance, treatment done per order. Even though R1's Braden scale risk assessments were performed R1's record did not show a causal analysis for the pressure ulcer sustained to coccyx area. Further, it was not evident R1's care plan identified that R1 developed a pressure ulcer or was revised to prevent additional pressure ulcers. In addition, R1's record lacked comprehensive pressure ulcer assessments when R1 developed a pressure ulcer to the coccyx to determine if the treatments that were completed helped heal the pressure ulcer. Record lacked a tissue tolerance test (a pressure test to determine how often a resident should be repositioned to prevent pressure ulcers), lacked daily monitoring of R1's skin and lacked weekly comprehensive wound assessments of R1's pressure ulcer to the coccyx. It lacked staging, characteristics, signs and symptoms of infection, and pain with dressing changes. R1's July 2024, treatment administration record (TAR) identified the physician order to change Mepilex dressing every 3 days and as needed. On 7/20/24 and 7/23/24 it was documented as completed. During an observation and interview on 7/24/24, at 1:35 p.m. nursing assistant (NA)-E and licensed practical nurse (LPN)-A were observed to toilet R1, Mepilex on coccyx was dated 7/19/24 (indicating the dressing was not changed in accordance with physician order), R1 was placed in the recliner after being toileted. During an interview on 7/24/24 at 1:45 p.m. director of nursing (DON) stated typically with any resident that has a wound they would go on the	2 900		

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2 900	Continued From page 7 wound list to be seen by the wound clinic, they are the only ones who do weekly measurements. DON indicated R1 was not on the wound clinic list and was unable to articulate why R1 was never on the list. R1 did have a pressure ulcer to the coccyx but understood it had since healed up and a Mepilex was used for protection. DON stated pressure ulcers were an area that need improvement and "are on our radar." Facility policy titled, "Skin Care," revised March 2017, identified each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care related to skin care; a person who enters the facility without pressure ulcers does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and the resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing ...c. interventions to ...g. provide an individualized repositioning program, h. provides daily monitoring of skin condition with at least weekly documentation ...j. for existing ulcers: 1. Monitor the ulcers characteristics, 2. Monitor the progress toward healing and potential complications, 3. Assess, treat, and monitor pain if present, 4. Monitor dressing and treatments ... SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of	2 900		

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2 900	Continued From page 8 pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		8/21/24

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2 910	Continued From page 9 Based on observation, interview, and document review the facility failed to develop an individualized toileting program to maintain or improve bowel/bladder continence resulting in a decline in continence for 1 of 1 residents (R1) reviewed for incontinence. Findings include: R1's admission minimum data set (MDS) dated 4/15/24, identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene, and was frequently incontinent bladder and always continent of bowel. R1's Bowel and Bladder assessment initiated on 4/15/24 and was completed on 4/16/24 identified R1 had a trial of a toileting program since urinary incontinence was noted in this facility. R1's toileting program response was unable to determine or trial in progress, R1 was frequently incontinent of bladder and always continent of bowel. R1 required limited assistance with toileting and was usually aware of toileting needs. R1 was identified to have urine leakage without sensation of urine loss, nocturia (greater than 2 times a night) and enuresis (bed wetting). Further identified R1 to have mixed incontinence, had mobility/manual dexterity impairments, lack of ability to get to the toilet or commode/bedpan without staff assist, recognized the appropriate time/place to void and defecate, able to feel the urge to void and was able to feel sensation for bowel movement. R1 appeared to be a good candidate for bowel/bladder retraining program, care plan will be initiated and will have increased	2 910	Corrected	

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2 910	Continued From page 10 episodes of bladder continence with initiation of toileting program and remain always continent of bowels through the review date. R1's care plan will include to toilet R1 prior to breakfast, upon arising from afternoon nap and at bedtime to try and prevent episodes of bladder incontinence. R1 had always been continent of bowels. Bowel pattern has varied between every other day and every third day since admission. Staff to assist R1 as needed or at times R1 will take himself. R1 had significant dementia and will not always communicate toileting needs and will wear a pull-up daily secondary to bladder incontinence. R1's provider orders dated 4/15/24 identified R1 should be toileted in AM prior to breakfast, upon arising from afternoon nap, and at bedtime to try and prevent some episodes of bladder incontinence. R1's record did not include a voiding diary and/or an assessment in order to identify R1's baseline or normal toileting routine in which the aforementioned toileting schedule was developed and implemented. R1's care conference note dated 4/26/24, identified R1 was frequently incontinent of bladder and always continent of bowel. R1's Bowel and Bladder assessment dated 6/18/24, identified R1 had a trial of a toileting program with no noted improvement. R1 was always incontinent of bladder and always incontinent of bowel. No bowel toileting program being used to manage R1's incontinence. R1 required extensive assistance with toileting. R1 was identified to have urine leakage without sensation or urine loss, nocturia and enuresis. Further identified R1 to have mixed incontinence, had mobility/manual dexterity impairments, lack of ability to get to the toilet or commode/bedpan	2 910		

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2 910	Continued From page 11 without staff assist, able to feel the urge to void and able to feel sensation for bowel movement. R1 appeared to be a good candidate for bowel/bladder retraining program, continue to current care plan. R1's significant change MDS, dated 6/18/24, identified R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene. Further identified R1 was always incontinent bladder and frequently incontinent of bowel. Even though R1's bowel and bladder assessments and MDS assessments showed a decline in continence, R1's record did not show a causal analysis. Further, it was not evident R1's toileting plan was revised to improve bowel and bladder incontinence and/or prevent decline. Additionally, the record did not indicate the physician was notified of R1's decrease in incontinence. R1's care plan edited 7/3/24, identified a problem with activities of daily living (ADL) dependencies, required assistance with adl's related to advanced Alzheimer's disease with significant memory deficits and inability to care for self. 7. Goal: toileting and continence, R1 will remain always continent of bowels and have decreased incontinence with current bladder retraining program through review date. Approaches: on 4/26/24, toileting plan to toilet R1 per schedule and if noted to be trying himself, R1 was frequently incontinent and required extensive assist of one staff with toileting, and on 4/30/24, R1 was always continent of bowel. R1's Point of Care history identified R1 was	2 910		

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2 910	Continued From page 12 supposed to be toileted three times a day. The record reviewed between 5/24/24 to 7/24/24 showed R1 was not always toileted per the care plan. Specific examples between 7/1/24 to 7/24/24 included the following: 7/1/24: toileted x 1 7/2/24: toileted x 1 7/3/24: toileted x 2 7/4/24: toileted x 2 7/5/24: toileted x 1 7/6/24: toileted x 1 7/7/24: toileted x 2 7/8/24: toileted x 3 7/9/24: toileted x 2 7/10/24: toileted x 3 7/11/24: toileted x 1 7/12/24: toileted x 2 7/13/24: toileted x 2 7/14/24: toileted x 1 7/15/24: toileted x 1 7/16/24: toileted x 1 7/17/24: toileted x 2 7/18/24: toileted x 1 7/19/24: not toileted 7/20/24: toileted x 3 7/21/24: toileted x 3 7/22/24: toileted x 2 7/23/24: toileted x 3 7/24/24: toileted x 1 During an observation on 7/24/24 at 1:35 pm, R1 was toileted by staff and had a wet brief. During an interview on 7/24/24 at 1:35 p.m., nursing assistant (NA)-E stated R1 was last toileted at 11:00 am and R1 had voided. During an interview on 7/24/24 at 1:45 p.m., DON stated R1 had a decline in bowel and bladder incontinence, when R1 went from always	2 910		

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2 910	Continued From page 13 continent of bowel and frequently incontinent of bladder to always incontinent of bowel and bladder. DON was unable to articulate a treatment and service plan to improve or maintain bowel and bladder. DON stated R1 should have been on a toileting plan to offer toileting every two hours not three times a day. Facility policy titled, "Bowel and Bladder Policy," revised 8/2023, indicated each resident receives the necessary care and service to attain or maintain the highest practicable level of bowel and bladder continence ...2. The comprehensive assessment results are used to develop a care plan addressing the individual needs of each resident. Care plan interventions are determined with consideration of: a. the ability of the resident to make decisions and call for assistance to use the toilet. B. The presence of permanent physical impairment or disease which could prevent incontinence. C. Resident's desire to participate in bowel and bladder programing. D. current standards of practice in accordance with state and federal law. 3. Review of the comprehensive assessment and care plan will occur on at least a quarterly basis and more frequently if there is a change in residents condition ... SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with incontinence to ensure cares services are implemnted to help maintain or prevent incontinence. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring.	2 910		

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2 910	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		