DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 28, 2022

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: August 1, 2022

Dear Administrator:

On September 9, 2022, 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.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 28, 2022

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: Reinspection Results
Event ID: 9Y8V12

Dear Administrator:

On September 9, 2022 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 August 1, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 23, 2022

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: August 1, 2022

Dear Administrator:

On August 1, 2022, 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 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 November 1, 2022 (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 February 1, 2023 (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,

Kamala Fiske-Downing

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

Electronically delivered
August 23, 2022

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: State Nursing Home Licensing Orders
Event ID: 9Y8V11

Dear Administrator:

The above facility was surveyed on July 27, 2022 through August 1, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 7/27/22 to 8/1/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H55853414C (MN85090), deficiencies were cited at F641. H55853279C (MN85054), deficiencies were cited at F655. Addtitional deficiencies were cited at F656, F604, and F689. The following complaints were found to be UNSUBSTANTIATED: H55853493C (MN83878) H5585028C (MN81880) H55853269C (MN84957) H55853508C (MN84441) 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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		9/1/22

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

Electronically Signed | 08/30/2022

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

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F 604	Continued From page 1 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R7) who utilized an electric reclining chair as a restraint.	F 604	F604 Right to be Free from Physical Restraints (D) Immediate corrective action: R7 was assessed for the use of the electric recliner. Based on the assessment findings, the electric recliner	

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F 604	Continued From page 2 Findings include: R7's Admission Record printed 7/29/22, indicated R7 had diagnoses which included dementia, obsessive compulsive disorder [(OCD) a common, chronic, and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and/or behaviors (compulsions) that he or she feels the urge to repeat over and over], and chronic obstructive pulmonary disease [(COPD) a lung disease that block airflow and make it difficult to breathe]. R7's admission record lacked indication R7 had a risk for falling. R7's significant change Minimum Data Set (MDS) dated 7/8/22, indicated R7 had severe cognitive impairment, altered level of consciousness and behaviors which included inattention and disorganized thinking. R7 required extensive assistance of two staff for bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and at risk for falls. However, lacked indication physical restraints were used. R7's Care Area Assessment cognitive (CAA) dated 7/8/22, indicated R7 had dementia and staff were to encourage resident to make simple day to day decisions and give him choices. R7's CAA further indicated staff needed to anticipate residents need. R7's care plan dated 2/21/19, indicated R7 had a mood problem related to dementia and repetitive behaviors of changing clothes and incontinent care products. The care plan indicated R7 liked to be clean and directed staff to allow resident to wander within the unit.	F 604	is no longer used for R7. Corrective Action as it Applies to Others: Residents that use electric recliners will be assessed to determine if the use of the device acts as a physical restraint. Residents who are not able to safely operate the recliner will have alternative interventions implemented to avoid the use of physical restraints. Prevent Recurrence: The policy and procedure for the use of Physical Restraints was reviewed and remains current. Nursing staff will be educated on the policy by 9/1/2022. Date of Alleged Compliance: 9/1/2022 Ongoing Monitoring: Random weekly audits will be completed for residents that use electric lift chairs to ensure ongoing compliance with facility policy for physical restraints. Audits will be completed as follows; 5 audits weekly x 2 weeks, 3 audits weekly x 2 weeks, 2 audits weekly x 4 weeks. A Summary of audit results will be reviewed during the monthly QAPI meeting for further recommendations. Completed By: Don/Designee	

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F 604	Continued From page 3 R7's Physician Orders dated 7/29/22, prescribed; Aricept (medication used for dementia) tablet 10 milligrams (mg) one tablet at bedtime and Sertraline (medication used for obsessive compulsive disorder and depression) HCL tablet 50 mg give 100 mg by mouth one time a day. Behavior Symptoms observation record from 7/14/22 to 7/24/22, indicated R7 had no behaviors observed or was not applicable. Facility Falls Incident Report dated 12/29/21 to 7/27/22, indicated R7 had 14 falls including; 3 unwitnessed falls on 3/8/22, 4/17/22, and 5/27/22; 5 witnessed falls on 1/16/22, 1/23/22, 2/18/22, 4/15/22, and 4/23/22; and 6 assisted falls (lowered to the floor) on 3/7/22, 3/8/22, 3/22/22, 3/26/22, 5/2/22, and 5/28/22. Nurse progress note dated 6/5/22, at 12:14 a.m. indicated R7 was restless during the shift, moving in his recliner. R7 was found with his legs on the fireplace. During observation on 7/27/22, from 8:30 a.m. to 9:45 a.m. R7 was observed in the fireside lounge next to the fireplace, lying supine (flat) on his back in an electric reclining chair with the feet elevated and the remote in the side pocket, out of resident's reach. R7 had awake time with eyes open, legs were moving up and down, and R7 was attempting to remove his shirt. Additionally, R7 was observed to squirm up and down in the chair. R7 appeared restless. No staff were observed in the area. R7 was not able to reach the remote to change positioning. During an observation on 7/27/22, at 1:53 p.m. R7 was in the fireside lounge next to the	F 604		

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F 604	Continued From page 4 fireplace, lying supine on his back in an electric reclining chair with the feet elevated and the remote in the chair pocket out of resident's reach. R7 appeared awake with eyes were open, and his arms and legs moving up and down. R7 took his left leg, lifted it up and touched the bricks above the fireplace. R7 appeared restless and no staff were observed in the area. R7 was not be able to reach the remote to change positioning. On 7/28/22, at 3:00 p.m. the director of nursing (DON) stated when R7 did not have access to the chair remote to change positions and was not able to get out of the recliner, it was considered a restraint. Further, staff should not be putting R7 in the recliner for convenience. On 7/28/22, at 6:00 p.m. licensed practical nurse (LPN)-A stated R7 was placed in the recliner "for convenience for the staff." because R7 was restless and wanted to constantly move. He needed more supervision. LPN-A stated staff were busy and were not able to keep an eye on R7 and provide redirection or an activity. On 8/1/22, at 2:45 p.m. the medical director stated when R7 was unable to reach the remote for the reclining chair, and in was in the reclined position, it may hinder R7 from exiting the recliner. He considered it a restraint. Medical Director further stated he had concerns regarding the amount of anti-psychotic medications used for R7. They made R7 at risk for falling and sleeping more. The facility policy Restraint Free Care dated 5/20, indicated a restraint may never be used for the purpose of discipline or staff convenience. The policy further indicated if a resident is retrained,	F 604		

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F 604	Continued From page 5 an assessment will be completed by a licensed nurse or therapist upon admission and thereafter, quarterly and or prior to application of any restraint to determine the appropriateness. The least restrictive device should be used with documentation of all other alternatives tried prior to the implementation of a restraint. The resident ' s physical environment should be assessed, and the facility should adapt the environment as appropriate to minimize restraint use.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for falls for 1 of 1 resident (R2) reviewed for MDS accuracy. Findings include: R2's admission MDS assessment dated 6/13/22, indicated R2 had moderate impaired cognition, used a walker, and required extensive assist of 1 staff for transfers, and ambulation. R2's MDS lacked evidence she had falls during her assessment period. R2's MDS indicated R2 had falls prior to admission which was not found in R2's history. R2's completed admission MDS, identified R2 had fractures related to falls in the 6 months prior to admission but no documentation to support this information. R2's initial care plan dated 6/7/22, directed staff	F 641	F641 Accuracy of Assessments (D) Immediate Corrective Action: The admission MDS for R2, dated 6/13/2022, was modified. Prevent Recurrence: The policy and procedure for Nursing Documentation was reviewed and remains current The MDS nurse will be educated on the policy by 9/1/2022 Ongoing Monitoring: Random weekly audits will be completed to ensure MDS's are completed in accordance with CMS and Medicare guidelines. Audits will be completed as follows; 5 audits weekly x 2 weeks, 3 audits weekly x 2 weeks, 2 audits weekly x 4 weeks. A Summary of audit results will be reviewed during the monthly QAPI meeting for further recommendations.	9/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 6 to provide assist of 1 with transfers and ambulation with the use of a gait belt and walker. R2's progress note dated 6/11/22, indicated on 6/11/22, R2 sustained a tear to her right Achille's tendon (disruption of the tendon just above the heel, resulting in inability to raise the foot). R2 was evaluated in the emergency room and was placed in a CAM boot (orthopedic device prescribed for the treatment and stabilization) and ordered to be non-weight bearing. R2's progress note dated 6/12/22, indicated R2 had an unwitnessed fall and was found lying on the floor. IDT Post Fall Review progress note dated 6/13/22, indicated R2 had an unwitnessed fall. When interviewed on 7/29/22, at 9:48 a.m. MDS nurse stated she had completed the assessment and did not indicate R2 had falls since admission. The MDS nurse further indicated the admission MDS was inaccurate. When interviewed on 7/28/22, at 4:00 p.m. the director of nursing (DON) stated her expectation was residents were accurately assessed to reflect the residents needs. The facility policy Nursing Documentation dated 5/20/22, indicated the facility will provide documentation in a standardized manner of the care and services provided to a resident. The policy directed staff to complete the MDS per CMS and Medicare guidelines.	F 641	Date of Alleged Compliance: 9/1/2022 Completed by: DON/Designee	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		9/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 655	Continued From page 7 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

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	245585	A. BUILDING _____ B. WING _____	C 08/01/2022

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F 655	Continued From page 8 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a person-centered, baseline care plan that included non-weight bearing interventions of assist with transfers, and all care needs to properly care for 1 of 1 residents (R2) reviewed for baseline care plan. Findings include: R2's progress notes dated 6/11/22, indicated that while walking with staff, R2 sustained a tear to her right Achille's tendon (tough band of fibrous tissue that connects the calf muscles to the heel bone (calcaneus)). R2 was sent to the Emergency Room (ER) and placed in a CAM boot (orthopedic device prescribed for the treatment and stabilization) on her right lower extremity, ordered to use a wheelchair and to be non-weight bearing until follow up appointment with podiatrist (foot doctor). R2's admission Minimum Data Set (MDS) assessment dated 6/13/22, indicated R2 was moderately cognitively impaired, required extensive assist of one for transfers and ambulation. Further, R2 required the use of a walker. R2's Baseline care plan initiated 6/7/22, directed staff to provide assist of one (1) with gait belt and walker for transfers and walking, independent, assistance at time and total assist with	F 655	F655 Baseline Care Plans (D) Immediate corrective action: The care plan for R2 was updated regarding non-weight bearing status Corrective Action as it Applies to Others: A review of baseline care plans will be completed for other residents to ensure interventions are implemented for residents with altered weight bearing status. Prevent Recurrence: The policy and procedure for the Care Plans was reviewed and remains current. Nursing staff will be educated on the policy by 9/1/2022. Date of Alleged Compliance: 9/1/2022 Ongoing Monitoring: Random weekly audits will be completed for residents with physician's orders or therapy recommendations for non-weight bearing status to ensure care plans reflect the current level of mobility. Audits will be completed as follows; 5 audits weekly x 2 weeks, 3 audits weekly x 2 weeks, 2 audits weekly x 4 weeks. A Summary of audit results will be reviewed during the monthly QAPI meeting for further recommendations. Completed By: Don/Designee	

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F 655	Continued From page 9 wheelchair. R2's care plan lacked indication her interventions were updated to include R2 was to be non-weightbearing of right lower extremitity, assist with transfers, and R2 required a CAM boot. R2's Fall Risk Assessment dated 6/9/22, indicted R2 was not a fall risk. R2's progress note dated 6/12/22, indicated R2 had an unwitnessed fall and was found lying on the floor. R2's IDT Post Fall Review progress note dated 6/13/22 R2's progress note dated 6/13/22, indicated R2 had an unwitnessed fall. When interviewed on 7/27/22, at 11:06 a.m. nursing assistant (NA)-A stated she was aware of R2 cares from the nurse report she received at the beginning of shift. When interviewed on 7/27/22, at 11:10a.m. NA-B stated tablets and paper care sheets are used for access to the residents care plan. She further stated nurses gave report and would update NA's during the shift as needed when changes occur. NA-B stated for new residents, she would go to the front of hard chart to review the temporary care plan. On 7/28/22, at 12:50 p.m. the director of nursing (DON) stated when a resident was admitted into the facility, a paper care plan was placed in the chart. She further stated the nurses reviewed the care plan with the NA's. The DON stated when interventions are ordered or needed to be implemented, they will needed to be added to the care plan.	F 655		

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F 655	Continued From page 10 During a follow up interview on 7/29/22, at 9:35 a.m. the DON verified R2's care plan had not been updated after R2 tore her Achille's Tendon or when she had her two (2) falls. The facility policy titled Care Plan-Review/Conferences dated 5/20, indicated the facility would review the care plans at least quarterly and as needed. The current State Operations Manual (SOM) states that because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.	F 655		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision during mealtime for 1 of 1 residents (R6) who had a diagnosis of dysphagia, history of aspiration pneumonia and was observed choking.	F 689	F689 Free of Accident Hazards/Supervision/Devices (D) Immediate corrective action: The care plan for R6 was updated to include interventions to ensure adequate	9/1/22

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F 689	Continued From page 11 Findings include: Upon entry to the facility on 7/27/22, at 9:40 a.m. R6 was seated in the fireside lounge at a table across from another female resident who was noncommunicative and demonstrated behaviors of throwing her cup and napkin. R6 took a drink of red color liquid from a glass and instantly began to cough. R6 proceeded to eat hot cereal. R6 suddenly started to gag. He had deep red coloration of his face, and a weak cough. R6's eyes teared onto his cheeks. R6 took his right hand, hit the table. With mouth closed, had a silent weak cough, as his chest was visibly rising. R6's suddenly took a deep cough and the hot cereal poured out of corner of his mouth down to the table. R6 continued to cough after expelling the hot cereal. No staff were observed during this time to monitor, supervise, offer R6 cues or assistance the female resident with behaivors. R6's physician orders dated 4/18/21, directed close supervision due to swallowing deficits and choking risk as indicated per speech therapy recommendation. Hospital discharge summary dated 4/25/22, indicated R6 's was started on antibiotics (medication to treat infection) Rocephin and Zithromax. Further, it indicated R6 had an episode of aspiration while drinking thickened milk products on 4/21/22. Care plan dated 4/25/22, indicated R6 had adequate intake related to usual good appetite and stable body weight. It directed staff to serve meals in the Main Dining room, serve diet as ordered, and monitor intake and record. R6's care	F 689	supervision is provided during mealtimes to decrease R6's risk for aspiration. Corrective Action as it Applies to Others: A review will be completed for other residents deemed at risk for aspiration to ensure care plans are developed that address the risk and need for supervision during mealtimes. Prevent Recurrence: The policy and procedure for Adequate Supervision was reviewed and remains current. Nursing staff will be educated on the policy by 9/1/2022. Date of Alleged Compliance: 9/1/2022 Ongoing Monitoring: Random weekly audits will be completed for residents with physician's orders for non-weight bearing status to ensure their care plans reflect their current level of mobility. Audits will be completed as follows; 5 audits weekly x 2 weeks, 3 audits weekly x 2 weeks. A Summary of audit results will be reviewed during the monthly QAPI meeting for further recommendations. Completed By: Don/Designee	

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F 689	Continued From page 12 plan lacked indication he was at risk for aspiration. Speech therapy (SLP) Evaluation and Treatment progress note dated 4/26/22, indicated R6 was hospitalized from 4/23/22 to 4/25/22, due to pneumonia, hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and suspect aspiration. SLP evaluation further indicated R6 was an aspiration risk and recommended close supervision, moderate cues, and assist with mechanical soft diet. R6 was also recommended to take sips to clear oral cavity, and to sit up right for 30 minutes after oral intake of food or fluids. R6 record lack evidence of a risk and benefits form completed regarding not wanting to follow recommendations of SLP for close observation. Physician progress note dated 5/23/22, indicated R6 had a medical history of aspiration pneumonia (pneumonia that is caused by something other than air being inhaled), chronic obstructive pulmonary disease (COPD) lung diseases that block airflow and make it difficult to breathe), coronary artery disease (CAD) Damage or disease in the heart's major blood vessels), chronic kidney disease stage 3 (CKD) kidneys are damaged and can't filter blood the way they should), and dementia. Quarterly Minimum Data Set (MDS) dated 6/3/22, indicated active diagnoses of aspiration pneumonia and dyshagia of the oropharyngeal phase. R6 required partial to moderate assistance with eating and limited physical assistant. R6 had no documentation of behaviors. However, the MDS lacked evidence of a swallowing disorder.	F 689		

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F 689	Continued From page 13 Significant change of condition MDS dated 6/25/22, indicated R6 had moderate cognitive impaired and required limited assistance with eating. R6's care area assessment (CAA) dated 6/25/22, indicated R6 had triggered nutritional due to BMI, weight gain and mechanically altered diet related to dyspphagia. R6's dietary nutritional risk tool dated 6/25/22, indicated meals in the main dining room, needed assistance, cueing to go slow, and to have ground meat. Further, it indicated R6 did not have a good short-term memory. On 7/29/22, at 1:30 p.m. director of nursing (DON) stated staff were to be within the fireplace lounge or nursing station to provide the necessary supervision for R6 during mealtimes. The DON stated R6 was at risk for aspiration when he had episodes of coughing and choking during breakfast with no staff within the area to provide interventions. On 8/1/22, at 12:00 p.m. R6 was observed seated at a table in the dining room with another unidentified resident. R6 had a spoon in his right hand grasping the handle and the tip of the bowl part of the spoon was pressed up to his chin. R6 was observed in that position for five minutes. R6 appeared to have a glazed unresponsive look on his face. No staff intervened during this time. Dietary staff were observed in the dining room and nursing assistant staff assisted other residents. On 8/1/22, at 12:45 p.m. speech language	F 689		

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F 689	Continued From page 14 therapist (SLP) stated R6 had a diagnoses of dysphagia and aspiration pneumonia and required close monitoring from staff at or near his table to be able to make eye contact. Further, she had observed R6 with different levels of alertness and sleepiness which increased risk for aspiration. SLP put diet recommendations in the communication book used in the dining room by staff and an additional copy in the resident's chart. On 8/1/22, at 2:00 p.m. medical director stated he expected staff to follow recommendation for supervision during meals for R6 due to history of aspiration pneumonia. The medical director further stated he had concerns for R6 and whether the facility had enough staffing to provide the overall supervision needed during mealtime. The medical director stated he was the previous primary care provider for R6 and had concerns his medication may have caused excessive sleepiness or lack of responsiveness which could increase risk for aspiration. On 8/1/22, at 4:15 p.m. corporate registered nurse (RN) stated when no staff were in the area in which R6 was seated when he was choking, it increased his risk for aspiration. Corporate RN further stated residents care plans needed to be more patient centered and individualized to each resident. Additionally, education on interventions, and appropriateness of interventions was needed to ensure residents received the right care. The facility policy titled Accidents Hazards, Supervision, Devices dated 3/21, indicated staff should provide adequate supervision to prevent accidents.	F 689		

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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 7/27/22 through 8/1/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H55853414C (MN85090), deficiencies were cited at F641. H55853279C (MN85054), deficiencies were cited at F655. Addtitional deficiencies were cited at F656, F604, and F689. The following complaints were found to be UNSUBSTANTIATED: H55853493C (MN83878) H5585028C (MN81880) H55853269C (MN84957) H55853508C (MN84441) The following complaint was found to be SUBSTANTIATED: H55853414C (MN85090), no licensing orders cited H55853279C (MN85054), deficiencies cited at 955 Additional deficiencies were cited at 0535. The following complaint was found to be UNSUBSTANTIATED: H55853493C (MN83878) H5585028C (MN81880) H55853269C (MN84957) H55853508C (MN84441) The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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2 535	MN Rule 4658.0300 Subp. 5 A-D Use of Restraints Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also: A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician; B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and elimination needs; C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and D. release the resident from the restraint as quickly as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R7) who utilized an electric reclining chair as a restraint. Findings include: R7's Admission Record printed 7/29/22, indicated R7 had diagnoses which included dementia, obsessive compulsive disorder [(OCD) a common, chronic, and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and/or behaviors (compulsions) that he or she feels the urge to repeat over and over], and chronic obstructive pulmonary disease [(COPD) a lung disease that block airflow and make it difficult to breathe]. R7's	2 535	Immediate corrective action: R7 was assessed for the use of the electric recliner. Based on the assessment findings, the electric recliner is no longer used for R7. Corrective Action as it Applies to Others: Residents that use electric recliners will be assessed to determine if the use of the device acts as a physical restraint. Residents who are not able to safely operate the recliner will have alternative interventions implemented to avoid the use of physical restraints. Prevent Recurrence: The policy and procedure for the use of Physical Restraints was reviewed and remains current. Nursing staff will be educated on the policy	9/1/22

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2 535	Continued From page 3 admission record lacked indication R7 had a risk for falling. R7's significant change Minimum Data Set (MDS) dated 7/8/22, indicated R7 had severe cognitive impairment, altered level of consciousness and behaviors which included inattention and disorganized thinking. R7 required extensive assistance of two staff for bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and at risk for falls. However, lacked indication physical restraints were used. R7's Care Area Assessment cognitive (CAA) dated 7/8/22, indicated R7 had dementia and staff were to encourage resident to make simple day to day decisions and give him choices. R7's CAA further indicated staff needed to anticipate residents need. R7's care plan dated 2/21/19, indicated R7 had a mood problem related to dementia and repetitive behaviors of changing clothes and incontinent care products. The care plan indicated R7 liked to be clean and directed staff to allow resident to wander within the unit. R7's Physician Orders dated 7/29/22, prescribed; Aricept (medication used for dementia) tablet 10 milligrams (mg) one tablet at bedtime and Sertraline (medication used for obsessive compulsive disorder and depression) HCL tablet 50 mg give 100 mg by mouth one time a day. Behavior Symptoms observation record from 7/14/22 to 7/24/22, indicated R7 had no behaviors observed or was not applicable. Facility Falls Incident Report dated 12/29/21 to 7/27/22, indicated R7 had 14 falls including; 3	2 535	by 9/1/2022. Date of Alleged Compliance: 9/1/2022 Ongoing Monitoring: Random weekly audits will be completed for residents that use electric lift chairs to ensure ongoing compliance with facility policy for physical restraints. Audits will be completed as follows; 5 audits weekly x 2 weeks, 3 audits weekly x 2 weeks, 2 audits weekly x 4 weeks. A Summary of audit results will be reviewed during the monthly QAPI meeting for further recommendations. Completed By: Don/Designee	

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2 535	Continued From page 4 unwitnessed falls on 3/8/22, 4/17/22, and 5/27/22; 5 witnessed falls on 1/16/22, 1/23/22, 2/18/22, 4/15/22, and 4/23/22; and 6 assisted falls (lowered to the floor) on 3/7/22, 3/8/22, 3/22/22, 3/26/22, 5/2/22, and 5/28/22. Nurse progress note dated 6/5/22, at 12:14 a.m. indicated R7 was restless during the shift, moving in his recliner. R7 was found with his legs on the fireplace. During observation on 7/27/22, from 8:30 a.m. to 9:45 a.m. R7 was observed in the fireside lounge next to the fireplace, lying supine (flat) on his back in an electric reclining chair with the feet elevated and the remote in the side pocket, out of resident's reach. R7 had awake time with eyes open, legs were moving up and down, and R7 was attempting to remove his shirt. Additionally, R7 was observed to squirm up and down in the chair. R7 appeared restless. No staff were observed in the area. R7 was not able to reach the remote to change positioning. During an observation on 7/27/22, at 1:53 p.m. R7 was in the fireside lounge next to the fireplace, lying supine on his back in an electric reclining chair with the feet elevated and the remote in the chair pocket out of resident's reach. R7 appeared awake with eyes were open, and his arms and legs moving up and down. R7 took his left leg, lifted it up and touched the bricks above the fireplace. R7 appeared restless and no staff were observed in the area. R7 was not be able to reach the remote to change positioning. On 7/28/22, at 3:00 p.m. the director of nursing (DON) stated when R7 did not have access to the chair remote to change positions and was not able to get out of the recliner, it was considered a	2 535		

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	00669	A. BUILDING: _____ B. WING _____	C 08/01/2022

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2 535	Continued From page 5 restraint. Further, staff should not be putting R7 in the recliner for convenience. On 7/28/22, at 6:00 p.m. licensed practical nurse (LPN)-A stated R7 was placed in the recliner "for convenience for the staff." because R7 was restless and wanted to constantly move. He needed more supervision. LPN-A stated staff were busy and were not able to keep an eye on R7 and provide redirection or an activity. On 8/1/22, at 2:45 p.m. the medical director stated when R7 was unable to reach the remote for the reclining chair, and in was in the reclined position, it may hinder R7 from exiting the recliner. He considered it a restraint. Medical Director further stated he had concerns regarding the amount of anti-psychotic medications used for R7. They made R7 at risk for falling and sleeping more. The facility policy Restraint Free Care dated 5/20, indicated a restraint may never be used for the purpose of discipline or staff convenience. The policy further indicated if a resident is retrained, an assessment will be completed by a licensed nurse or therapist upon admission and thereafter, quarterly and or prior to application of any restraint to determine the appropriateness. The least restrictive device should be used with documentation of all other alternatives tried prior to the implementation of a restraint. The resident ' s physical environment should be assessed, and the facility should adapt the environment as appropriate to minimize restraint use. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to restraints and monitor for compliance.	2 535		

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2 535	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 535		
2 955	MN Rule 4658.0530 Subp. 3 Assistance with Eating - Risk of Choking Subp. 3. Risk of choking. A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision during mealtime for 1 of 1 residents (R6) who had a diagnosis of dysphagia, history of aspiration pneumonia and was observed choking. Findings include: Upon entry to the facility on 7/27/22, at 9:40 a.m. R6 was seated in the fireside lounge at a table across from another female resident who was noncommunicative and demonstrated behaviors of throwing her cup and napkin. R6 took a drink of red color liquid from a glass and instantly began to cough. R6 proceeded to eat hot cereal. R6 suddenly started to gag. He had deep red coloration of his face, and a weak cough. R6's	2 955	Immediate corrective action: The care plan for R6 was updated to include interventions to ensure adequate supervision is provided during mealtimes to decrease R6's risk for aspiration. Corrective Action as it Applies to Others: A review will be completed for other residents deemed at risk for aspiration to ensure care plans are developed that address the risk and need for supervision during mealtimes. Prevent Recurrence: The policy and procedure for Adequate Supervision was reviewed and remains current. Nursing staff will be educated on the policy by 9/1/2022.	9/1/22

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2 955	Continued From page 7 eyes teared onto his cheeks. R6 took his right hand, hit the table. With mouth closed, had a silent weak cough, as his chest was visibly rising. R6's suddenly took a deep cough and the hot cereal poured out of corner of his mouth down to the table. R6 continued to cough after expelling the hot cereal. No staff were observed during this time to monitor, supervise, offer R6 cues or assistance the female resident with behaivors. R6's physician orders dated 4/18/21, directed close supervision due to swallowing deficits and choking risk as indicated per speech therapy recommendation. Hospital discharge summary dated 4/25/22, indicated R6 's was started on antibiotics (medication to treat infection) Rocephin and Zithromax. Further, it indicated R6 had an episode of aspiration while drinking thickened milk products on 4/21/22. Care plan dated 4/25/22, indicated R6 had adequate intake related to usual good appetite and stable body weight. It directed staff to serve meals in the Main Dining room, serve diet as ordered, and monitor intake and record. R6's care plan lacked indication he was at risk for aspiration. Speech therapy (SLP) Evaluation and Treatment progress note dated 4/26/22, indicated R6 was hospitalized from 4/23/22 to 4/25/22, due to pneumonia, hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and suspect aspiration. SLP evaluation further indicated R6 was an aspiration risk and recommended close supervision, moderate cues, and assist with mechanical soft diet. R6 was also recommended to take sips to clear oral cavity,	2 955	Date of Alleged Compliance: 9/1/2022 Ongoing Monitoring: Random weekly audits will be completed for residents with physician's orders for non-weight bearing status to ensure their care plans reflect their current level of mobility. Audits will be completed as follows; 5 audits weekly x 2 weeks, 3 audits weekly x 2 weeks. A Summary of audit results will be reviewed during the monthly QAPI meeting for further recommendations. Completed By: Don/Designee	

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2 955	Continued From page 8 and to sit up right for 30 minutes after oral intake of food or fluids. R6 record lack evidence of a risk and benefits form completed regarding not wanting to follow recommendations of SLP for close observation. Physician progress note dated 5/23/22, indicated R6 had a medical history of aspiration pneumonia (pneumonia that is caused by something other than air being inhaled), chronic obstructive pulmonary disease (COPD) lung diseases that block airflow and make it difficult to breathe), coronary artery disease (CAD) Damage or disease in the heart's major blood vessels), chronic kidney disease stage 3 (CKD) kidneys are damaged and can't filter blood the way they should), and dementia. Quarterly Minimum Data Set (MDS) dated 6/3/22, indicated active diagnoses of aspiration pneumonia and dyshagia of the oropharyngeal phase. R6 required partial to moderate assistance with eating and limited physical assistant. R6 had no documentation of behaviors. However, the MDS lacked evidence of a swallowing disorder. Significant change of condition MDS dated 6/25/22, indicated R6 had moderate cognitive impaired and required limited assistance with eating. R6's care area assessment (CAA) dated 6/25/22, indicated R6 had triggered nutritional due to BMI, weight gain and mechanically altered diet related to dyspphagia. R6's dietary nutritional risk tool dated 6/25/22, indicated meals in the main dining room, needed assistance, cueing to go slow, and to have	2 955		

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2 955	Continued From page 9 ground meat. Further, it indicated R6 did not have a good short-term memory. On 7/29/22, at 1:30 p.m. director of nursing (DON) stated staff were to be within the fireplace lounge or nursing station to provide the necessary supervision for R6 during mealtimes. The DON stated R6 was at risk for aspiration when he had episodes of coughing and choking during breakfast with no staff within the area to provide interventions. On 8/1/22, at 12:00 p.m. R6 was observed seated at a table in the dining room with another unidentified resident. R6 had a spoon in his right hand grasping the handle and the tip of the bowl part of the spoon was pressed up to his chin. R6 was observed in that position for five minutes. R6 appeared to have a glazed unresponsive look on his face. No staff intervened during this time. Dietary staff were observed in the dining room and nursing assistant staff assisted other residents. On 8/1/22, at 12:45 p.m. speech language therapist (SLP) stated R6 had a diagnoses of dysphagia and aspiration pneumonia and required close monitoring from staff at or near his table to be able to make eye contact. Further, she had observed R6 with different levels of alertness and sleepiness which increased risk for aspiration. SLP put diet recommendations in the communication book used in the dining room by staff and an additional copy in the resident's chart. On 8/1/22, at 2:00 p.m. medical director stated he expected staff to follow recommendation for supervision during meals for R6 due to history of aspiration pneumonia. The medical director	2 955		

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2 955	Continued From page 10 further stated he had concerns for R6 and whether the facility had enough staffing to provide the overall supervision needed during mealtime. The medical director stated he was the previous primary care provider for R6 and had concerns his medication may have caused excessive sleepiness or lack of responsiveness which could increase risk for aspiration. On 8/1/22, at 4:15 p.m. corporate registered nurse (RN) stated when no staff were in the area in which R6 was seated when he was choking, it increased his risk for aspiration. Corporate RN further stated residents care plans needed to be more patient centered and individualized to each resident. Additionally, education on interventions, and appropriateness of interventions was needed to ensure residents received the right care. The facility policy titled Accidents Hazards, Supervision, Devices dated 3/21, indicated staff should provide adequate supervision to prevent accidents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to supervision of residents at risk for choking and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 955		