



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 12, 2023

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: October 20, 2022

Dear Administrator:

On November 28, 2023, we notified you a remedy was imposed. On December 7, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 18, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 20, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 7, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 18, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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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January 12, 2023

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: Reinspection Results
Event ID: NT0112 and DMEQ12

Dear Administrator:

On December 7, 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 surveys completed on October 20, 2022 and November 9, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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November 7, 2022

Administrator
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1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: October 20, 2022

Dear Administrator:

On October 20, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 January 20, 2023 (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).

Good Samaritan Society - St James

November 7, 2022

Page 3

In addition, if substantial compliance with the regulations is not verified by April 20, 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,



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
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Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: State Nursing Home Licensing Orders
Event ID: NT0111

Dear Administrator:

The above facility was surveyed on October 18, 2022 through October 20, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245593	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2022
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST JAMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
(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 10/18/22, to 10/20/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H55935183C (MN87614), with deficiencies cited at (F686, F755, F580) 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 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580			11/18/22

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

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 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure provider was notified of a change	F 580	Preparation and execution of this response and plan of correction does not		

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F 580	Continued From page 2 in condition for 2 of 2 residents (R2 and R6) for weight gain and elevated blood pressure. Findings include: R2 R2's facesheet printed on 10/20/22, included admission diagnoses of heart failure, chronic kidney disease and hypertension (high blood pressure). On 9/21/22, pneumonia was added. R2's admission Minimum Data Set (MDS) assessment dated 8/26/22, indicated moderately impaired cognition. R2 had adequate vision and hearing, unclear speech, was usually understood and could usually understand. R2 required extensive assistance of one or two staff for most activities of daily living. R2's care plan dated 8/22/22, indicated R2 had hypertension and CHF (congestive heart failure) and R2 would remain free from hypertension and complications related to hypertension. Staff would monitor, document and report symptoms such as lethargy (drowsiness and lack of mental alertness), or difficulty breathing. In addition the care plan indicated R2 had renal failure and would have no complications related to fluid overload. Staff were to monitor for changes in mental status and to elevate feet when up in chair to prevent dependent edema. The care plan interventions did not include monitoring weight. A provider order dated 8/27/22, indicated daily weights and to notify a physician if R2 gained greater than 2 lbs (pounds) in 24 hours or 5 lbs in 7 days. Monitor for SOB (shortness of breath), bloating and decreased endurance.	F 580	constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F580 Notify of Changes (Injury/Degrade/Room, etc.) 1. R2 discharged from the facility on 10/5/22 and R6 was deceased on 11/3/22. 2. All residents with a change in condition have the potential to be affected. A dashboard review will be conducted by the DON or designee during morning meetings to ensure residents with significant weight changes and abnormal blood pressures are addressed promptly and reported to the provider if applicable. Baseline blood pressures will be established for all residents by 11/18/22. All residents were reviewed for significant weight gain/loss and elevated blood pressures by the DON on 11/10/22 and reported to the PCP as necessary. 3. Education on GSS Policy "Change in Condition Evaluation" and "Weight and Height," and "Vital Signs- Blood Pressure" will be reviewed by the DON or designee with all nursing staff by 11/18/22. The process for conducting weight loss/gain assessments was posted at the		

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F 580	Continued From page 3 During record review, a visit note dated 9/19/22, by nurse practitioner (NP)-C indicated R2 was found to have increased weight gain. Current weight had been 143 lbs and admission weight was 136 lbs. In addition, the note indicated R2 had been spending more time in bed and therapy had reported R2 had not been participating as well as she had been. Furthermore, NP-C hand-wrote a note indicating R2 had weight gains greater than 2.5 lbs in 24 hours and there had been no progress note indicating a provider was informed. During record review, weight gains of greater than 2 lbs in 24 hours were: 9/1/22 to 9/2/22: gain of 7 lbs (142 lbs to 149 lbs). 9/5/22 to 9/6/22: gain of 2.5 lbs (142 lbs to 144.5 lbs). 9/13/22 to 9/14/22: gain of 2.5 lbs (141 lbs to 143.5 lbs). 9/15/22 to 9/16/22: gain of 2.5 lbs (140.5 lbs to 143 lbs). During record review, nursing progress notes from 9/1/22, through 9/16/22, did not identify awareness of R2's weight gains. During an interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A stated R2 came in with fluid retention. RN-A could not recall specific orders regarding notifying a provider of R2's weight increases. RN-A stated if there had been specific orders, she would have followed them and documented it in a progress note. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated she had been concerned about lack of notification of R2's weight gains. NP-C	F 580	nurse's station on 11/8/22. 4. Audits will be conducted for 5 random residents by the Quality Assurance Coordinator or designee twice weekly x 1 month and weekly x 2 months to ensure that significant weight changes and abnormal blood pressures are addressed promptly and reported to the provider if applicable. Audit results will be brought to the QAPI committee for further recommendations.		

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F 580	Continued From page 4 stated she had increased R2's diuretics because R2 had been gaining weight and had a history of heart failure. NP-C stated while there had not been a negative outcome, prolonged fluid overload could cause worsening of heart failure and therefore was important for staff to monitor R2's weight closely and report weight gains to a provider. During an interview on 10/20/22, at 10:41 p.m., licensed practical nurse (LPN)-A stated that the EMR (electronic medical record) triggered a warning with significant weight gains or losses and displayed the alert prominently on EMR when a specific residents record was accessed. When that occurred, LPN-A stated a nurse was supposed to re-weigh the resident, review past weights, check vital signs, and assess lung sounds, then notify a provider. LPN-A was aware of R2 being monitored for weight gain; but not aware of any recent increases. During an interview on 10/20/22, at 12:55 p.m., nursing assistant (NA)-B stated she entered resident weights in the EMR, and the EMR would alert if there was a weight gain or decrease. In that case, the NA would inform a nurse. NA-B stated she had informed nurses in the past of weight gains, but didn't recall for which residents. NA-B stated she would only inform a nurse of a weight gain if a warning came up in the EMR. During an interview on 10/20/22, at 1:15 p.m., trained medication aide (TMA)-A stated if a resident had a weight gain, she would get an alert in the EMR and would tell a nurse. TMA-A did not recall informing a nurse of a weight gain for R2. During an interview on 10/20/22, at 1:55 p.m., the	F 580			

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F 580	Continued From page 5 director of nursing (DON) stated staff were to report significant increases and decreases in resident weights, but was unaware if there was a policy identifying what would be considered significant, adding it would depend on the resident. The DON stated she expected staff to notify a provider if a resident gained or lost a significant amount of weight or if a provider wrote an order with specific parameters on when to notify them. R6 R6's face sheet printed on 10/20/22, included diagnoses of hypertensive kidney disease and diabetes. R6's quarterly MDS assessment dated 10/2/22, indicated R6 had severely impaired cognition, adequate vision and hearing, clear speech and was sometimes understood. R6 required extensive assistance of one or two staff for activities of daily living. R6's care plan dated 10/15/22, indicated R6 had hypertension. No other information was listed, including interventions. During record review, a visit note dated 9/14/22, by NP-C indicated R6's blood pressures were markedly elevated and there had been no rechecks after medications were given. The note indicated parameters for nursing staff to follow: if blood pressure was greater than 170 and or diastolic greater than 95, then recheck in 30 minutes making sure R6 was not symptomatic. If symptomatic, a provider would need to be notified. Further, lisinopril (blood pressure	F 580			

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F 580	Continued From page 6 medication) 20 mg was changed to the evening, and norvasc (blood pressure medication) 5 mg daily was started. During record review, blood pressures for 9/1/22, through 9/14/22, indicated R6 had multiple instances of an elevated blood pressure with auto-generated warnings noted in the EMR for 11 of the 16 blood pressures noted below, indicating either a systolic high of 139 or diastolic high of 89 had been exceeded. 9/1/22: 166/89 9/2/22: 177/128 9/3/22: 183/102 9/4/22: 148/113 and 166/110 9/5/22: 183/103 9/6/22: 186/102 9/7/22: 190/113 9/8/22: 179/96 9/9/22: 177/105 9/10/22: 163/91 9/11/22: 166/93 9/12/22: 150/94 9/13/22: 149/88 9/14/22: 143/109 and 156/108 During record review from 9/1/22, through 9/14/22, there were no nursing progress notes indicating awareness of the elevated blood pressures, an assessment of R6 for symptoms of elevated blood pressure or notification to a provider. During a telephone interview on 9/19/22, at 7:35 p.m., NP-C stated when R6's blood pressures were to be significantly elevated, NP-C took the blood pressures to the charge nurse and asked why a provider had not been notified. NP-C pointed out to the nurse (unidentified) that the	F 580			

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F 580	Continued From page 7 elevated blood pressures would have automatically triggered a warning in the EMR. The nurse stated she had not been aware of the elevated blood pressures. NP-C stated the risk of untreated hypertension for R6 was hypertensive crisis and heart damage. During an interview on 10/20/22, at 9:41 a.m., LPN-A stated nursing assistants (NA) obtained all of the vital signs, documented them on a paper "vital signs sheet" and also entered them into the EMR. LPN-A stated nurses were to review the vital signs throughout their shift. In addition, NA's were to notify the nurse of elevated blood pressures, but was aware that did not always happen. LPN-A stated the EMR automatically identified abnormal vital signs and it was a clear visual to nurses, but wasn't sure if each nurse looked at the abnormal vital signs. LPN-A was not aware of R6's having elevated blood pressures in September. During an interview on 10/20/22, at 11:55 a.m., the DON stated in regard to an elevated blood pressure, a provider should be notified for "anything extremely off." The DON didn't know if there were blood pressure parameters that would direct a nurse when to notify a provider and was not aware if there was a facility policy addressing this. The DON admitted a provider should be notified for a blood pressure with a diastolic reading over 100, and was not aware of R6 having elevated blood pressures. During an interview on 10/20/22, at 1:15 p.m., trained medication aide (TMA)-A confirmed she obtained resident vital signs using a vital signs machine. TMA-A stated most resident blood pressures were low. Together looked at the vitals	F 580			

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F 580	Continued From page 8 signs sheet and a blood pressure for a random resident indicated 164/84. TMA-A stated it was a little high, but "we know our residents" and TMA-A didn't consider that to be abnormal for this resident, so would not report it to a nurse. During the same interview, TMA-A pointed out a small laminated card attached to the vital signs machine titled Normal ranges for vital signs and which read: If a residents vitals signs are above or below these ranges, please tell a nurse immediately. Blood pressure 90/60 - 120/80. Report to the nurse if the pressure is above 139/89 or below 90/60, or the resident is complaining of lightheadedness, dizziness, blurred vision and/or pulse 60-100, respirations 12-18, temperature 97.8 - 99.1, O2 (oxygen) level anything below 90% report to a nurse. TMA-A read the card and admitted the blood pressure parameter were confusing as they indicated two different parameters, adding she didn't think anyone looked at the card. During an interview on 10/20/21, at 1:55 p.m., the DON was shown a copy of the card attached to the vitals signs machine; was unaware of this card and admitted it did not provide clear guidance to NA's for when to inform a nurse of a blood pressure reading. The DON stated she expected NA's to notify a nurse of elevated blood pressures, but would have to determine the appropriate parameters for that. Further, the DON expected nurses to be aware of elevated blood pressures, to assess the resident for symptoms and to notify a provider. Facility policy titled Vital Signs - Blood Pressure dated 9/22/22, indicated the steps in obtaining a blood pressure.			F 580			

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F 580	Continued From page 9	F 580			
F 686 SS=D	Facility policy titled Weight and Height dated 9/22/22, indicated staff were to report significant weight changes immediately to a physician. Significant weight change was defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days. The licensed nurse would immediately notify the medical provider regarding any significant weight change. 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 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 interview and document review, the facility failed to comprehensively assess and reassess to ensure adequate routine monitoring of pressure ulcers was completed and recorded for 1 of 1 residents (R3) reviewed for pressure ulcer care and services. Findings include: Pressure Ulcer stages defined by the Minimum	F 686	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the		11/18/22

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F 686	Continued From page 10 Data Set (MDS) per Center Medicare/Medicaid Services: Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) R3's face sheet printed on 10/20/22, included admission diagnoses of cerebral infarction	F 686	center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F686 Treatment/Services to Prevent/Heal Pressure Ulcer 1. Daily wound data collections and weekly wound RN assessments will be completed for R3 until wounds are healed. 2. All residents with pressure ulcers were reviewed by the DON on 11/8/22. Daily wound data collections and weekly RN assessments have been scheduled to be completed for these residents until they are healed. 3. Education on GSS Policy "Pressure Ulcer Prevention and Documentation Requirements" will be reviewed by the DON or designee by 11/18/22 with all nurses. 4. Audits will be conducted for R3 and 3 other random residents with pressure ulcers by the Quality Assurance Coordinator or designee five times weekly x 2 weeks, three times weekly x 2 weeks, twice weekly x 2 weeks, and 1x weekly x 2 months to ensure wound data collections are being completed daily and wound RN assessments weekly for residents with pressure ulcers. Audit results will be brought to the QAPI committee for further recommendations.		

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F 686	Continued From page 11 (stroke) with hemiplegia (paralysis on one side of the body), dementia, diabetes, chronic kidney disease, protein-calorie malnutrition, anemia, contracture of multiple muscles, pressure ulcer of sacral region (located below the lumbar spine and above the tailbone, which is known as the coccyx) - stage 4, pressure ulcer of right heel - unstageable, pressure ulcer of left hip - unstageable. R3's admission Minimum Data Set (MDS) assessment dated 9/6/22, indicated R3 had severely impaired cognition. R3 did not speak, his hearing was highly impaired, vision was severely impaired and he was rarely/never understood nor did he understand. R3 did not walk and required extensive assistance of two staff for bed mobility and toileting. R3 was totally dependent upon two staff and a mechanical lift for transfers. R3's care plan revised on 9/13/22, indicated R3 had impairment to skin integrity related to malnourishment brought on by CVA (cardiovascular accident, or stroke) and would have no complications related to skin integrity concerns identified upon admission. R3's pressure ulcers would show signs of healing and remain free from infection. Interventions included pressure reducing mattress and heel protectors; repositioning every two hours while in bed or chair. The care plan did not indicate monitoring pressure ulcers for location, size and stage. Braden scale for predicting pressure sore risk indicated R3 had been a high risk and a very high risk for PU development when assessed on 8/31/22, and 10/18/22, respectively. R3 had multiple physician orders for monitoring of	F 686			

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F 686	Continued From page 12 the pressure ulcers, but no specific order to measure or stage pressure ulcers. During record review, an admission visit note by medical doctor (MD)-E dated 9/7/22, indicated R3 had a chronic sacral pressure ulcer with chronic osteomyelitis (bone infection). The note indicated R3 had been in the hospital multiple times over the past year with continued decline and was on comfort cares. While the sacral ulcer was mentioned, there were no sacral ulcer measurements included in the note. Further, the note indicated R3 had skin care to buttocks, bilateral heels, coccyx, and left knee. These wounds were not identified as PUs or non-pressure related wounds. During record review, a progress note by nurse practitioner (NP)-C dated 10/5/22, indicated R3's sacral ulcer to be worsening. No measurement or staging of the sacral ulcer was included in the note. During this visit, photographs were taken of various area of R3's wounds with a tape measure across the wound, but no actual measurements were listed. The reader would need to determine measurements based upon the photos. Over the course of seven weeks (admission on 8/31/22, to 10/19/22), according to wound data collection documents provided by the director of nursing (DON) (unless otherwise indicated), the sacral ulcer was assessed at least six times, however lacked a comprehensive assessment. Documentation as follows: 1. During record review, a note by NP-C dated 9/19/22, indicated the sacral wound measured 3 cm (centimeter) x 2 cm x 2.5 cm, with 3 cm undermining and bone exposure.	F 686			

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F 686	Continued From page 13 2. 9/20/22, at 11:40 p.m., indicated 3 cm in length x 2.5 cm in width x 3 cm in depth. Undermining of 3 cm. Incomplete wound characteristics were documented: moderate sanguineous drainage was documented, but no percentage of various type of tissue healing, e.g., epithelialized, granulation, slough, or eschar. 3. 9/21/22, at 9:50 p.m. No measurements or wound characteristics, only moderate sanguineous drainage was documented. 4. 10/14/22, via progress note by RN-A: 5.0 cm x 3.0 cm x 2 cm. RN-A sent a message to DON to confirm she was aware of increase in size of the sacral PU. 5. 10/16/22, via progress note by RN-A: 5.0 cm x 3.0 cm x 2 cm. The progress note indicated MD-E was notified with the concern the sacral wound was getting bigger. MD-E replied that is was not getting bigger. 6. 10/19/22, 3:30 p.m. Measurements indicated worsening of the sacral PU: 6.9 cm in length, 4.5 cm in width, no depth or undermining was documented. Epithelialized tissue was 10% and granulated tissue was 90%. Moderate sanguineous drainage. Wound margins were listed as intact, pink and macerated - softened, wrinkled tissue due to moisture. During an interview on 10/18/22, at 4:00 p.m., the director of nursing stated R3 had been living with family who neglected him, and that R3 was admitted to the facility with multiple pressure ulcers. The DON stated the majority of the time, R3's PUs were assessed and measured by	F 686			

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F 686	Continued From page 14 NP-C, although some nurses took measurements too. The DON stated the expectation for a comprehensive assessment was weekly, but she didn't hold staff accountable to that because she was new and didn't know for sure how often it should be done. The DON admitted she could have reviewed the PU policy to learn this. The DON stated not all nurses felt comfortable measuring PU's and felt they lacked the competency to measure the more extensive PU on R3's sacrum. The DON acknowledged that in order to determine if a PU was improving or worsening, the PU would need to be assessed weekly with measurements and staging, and a comparison made to previous measurements. The DON admitted this had not been done. The DON was asked to have R3's PU's measured, and to provide documentation of each of R3's PU assessments since admission. Furthermore, the DON stated NP-C who had been doing the majority of R3's PU assessments had stopped seeing residents at the facility after 10/5/22. A different NP had taken over who did not measure or stage PUs. Despite learning this on 10/4/22, no action had been taken to determine who would perform weekly comprehensive assessments of R3's PU. During an interview on 10/20/22, at 8:35 a.m., nursing assistant (NA)-A stated R3 was repositioned every two hours, but no matter what, R3 always wiggled back onto his back, that he did not like to lay on his side. On 10/20/22, at 12:00 p.m., the DON provided 49 wound data collection forms for R3, for multiple wounds and pressure ulcers in 15 locations dating from 8/31/22, through 10/19/22. The documentation failed to indentify whether the	F 686			

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F 686	Continued From page 15 wound was a PU or a non-pressure related wound. Documentation failed to show PU assessments were performed weekly until healed. The forms varied in terms of a comprehensive assessment as most lacked measurements and wound characteristics. No PU's were staged. After reviewing all of the forms and interviewing staff (interviews below with LPN-A and NP-C), it was determined the only remaining PU was to the sacrum -- all other wounds either did not fit the description of a PU, and/or had healed. During an interview on 10/20/22, at 1:28 p.m., (NP)-D stated she told the facility on 10/5/22, that she does not do wound management and recommended contacting their corporate office find out how wound management could be accomplished as it was important to have a consistent person assessing the wounds and doing the measurements. During an interview and observation on 10/20/22, at 1:38 p.m., with licensed practical nurse (LPN)-A, observed dressing changes to R3's sacrum and several other wounds. Sacral ulcer appeared to be approximately 2.5 inches x 2.5 inches. Clean wound edges. Bone of the spine visible. LPN-A stated other than the sacrum, R3 had no other open wounds. R3 was on a pressure relieving mattress. During a telephone interview on 10/20/22, at 2:09 p.m., NP-C confirmed the only wound open right now had been the sacrum. NP-C stated the facility was doing the best they could given R3's weight, nourishment and inability to stay off his sacrum, but someone needed to continue to evaluate and assess R3's PU's regularly to	F 686			

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F 686	Continued From page 16 determine worsening or improvement. Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation dated 4/26/22, indicated the purpose was to accurately document observations and assessments of residents. If a pressure ulcer was identified the registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA (i.e., for a PU, record the stage). The licensed nurse recorded the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection UDA. Skin tears, abrasions and bruises were not intended to be recorded on this form. Interdisciplinary team should determine any modifications that were necessary to the residents plan of care. When a PU was present, daily monitoring should occur. The PU should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA. Observations should include: measurements - length, width, depth, characteristics - including wound bed, undermining, tunneling, exudate, surrounding skin, presence of pain, current treatments. Progress toward healing and modifications to the plan of care/treatments should be assessed and evaluated by the RN. In-services for nursing and other disciplines would be held as necessary and would include: pressure ulcer protocols and guidelines, skin observation and assessments, instruction of accurate documentation.	F 686			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755			11/18/22

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F 755	Continued From page 17 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to promptly process medication orders for 3 of 3 residents (R2, R7 and R3) resulting in a delay in receiving medications prescribed for fluid retention, infection, pain and itching. Findings include:	F 755	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed		

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F 755	Continued From page 18 R2 R2's facesheet printed on 10/20/22, included diagnoses of heart failure, chronic kidney disease, and hypertension (high blood pressure). R2's admission Minimum Data Set (MDS) assessment dated 8/26/22, indicated moderately impaired cognition. R2 had adequate vision and hearing, unclear speech, was usually understood and could usually understand. R2 required extensive assistance of one or two staff for most activities of daily living. R2's care plan dated 8/22/22, indicated R2 had hypertension and CHF (congestive heart failure) and R2 would remain free from hypertension and complications related to hypertension. Staff would monitor, document and report symptoms such as lethargy (drowsiness and lack of mental alertness), or difficulty breathing. During record review, a visit note dated 9/19/22, indicated R2 was seen by nurse practitioner (NP)-C and found to have increased weight gain from 136 lbs (pounds) to 143 lbs and was spending more time in bed. NP-C ordered an increase in Lasix (diuretic) to 60 mg daily and ordered metolazone (diuretic) 2.5 mg daily for 3 days. During record review, a visit note dated 9/21/22, indicated R2 was seen by NP-C who discovered the diuretics ordered on 9/19/22, had not been started. During record review, R2's medication administration record (MAR) indicated Lasix 60	F 755	solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F755 Pharmacy Services/Procedures/Pharmacist/Records The facility failed to promptly process medication orders for 3 of 3 residents (R2, R7, and R3) resulting in a delay in receiving medications prescribed for fluid retention, infection, pain, and itching. 1. R2 discharged from the facility on 10/5/22. Medication orders for R3 and R7 were processed on 9/15/22 for R7 and 9/29/22 for R3. 2. All residents that have medication orders have the potential to be affected. Orders will be transcribed the same day they are received to ensure timeliness of any medication changes. 3. Education on GSS Policy "Physician/Practitioner Orders" will be reviewed by the DON or designee with all nurses by 11/18/22. 4. Audits will be completed for R3 and R7 and 3 other random residents with medication orders by the Quality Assurance Coordinator or designee three times weekly x 1 month and weekly x 2 months to ensure medications orders are transcribed into Point Click Care timely. Audit results will be brought to the monthly QA meeting for further recommendations.		

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F 755	Continued From page 19 mg daily and metolazone 2.5 mg daily for 3 days, were started on 9/21/22, two days after they were ordered. During a telephone interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A was unaware of a delay in starting diuretics for R2 , adding, "That's one thing they do different there...provider orders are processed by whomever can get to them," and added it was hard to access paper orders once they were signed off as they were kept locked somewhere...no way to review them. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated an increase in diuretics had been order because R2 had been gaining weight and had a history of heart failure. NP-C stated while there was not a negative outcome, prolonged fluid overload could cause worsening of heart failure. During an interview on 10/20/22, at 9:41 a.m., licensed practical nurse (LPN)-A was aware after the fact of the delay in processing the chest x-ray for R2. LPN-A explained that in the past, one nurse (the MDS nurse) entered all provider orders into the electronic medical record (EMR), and as a result nurses working on the floor were not used to processing orders. When this nurse separated employment, the process for floor nurses to enter orders was not well-defined and as a result, some orders were not processed timely. LPN-A stated he was then moved to day shift charge nurse position in order to provide consistency and to ensure orders were processed timely. In addition, LPN-A stated he created a written process to guide the nurses in processing provider orders and educated staff on the process. The new written process was reviewed.	F 755			

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F 755	Continued From page 20 During an interview on 10/20/2022, at 11:25 p.m., the director of nursing (DON) stated she had not initially been aware of the delay in processing the orders for the diuretics for R2. The DON stated she discovered the diuretic order had been missed when doing random audits of provider orders. The DON stated the order was missed because, "I don't think the nurses got to the order." The DON stated provider orders were placed in a box at the nurses station for the charge nurse to process, and the order for R2's diuretics had not been processed timely. The DON stated nurses were not supposed to leave their shift until everything was done, including processing new orders. The DON acknowledged she had responsibility for oversight of nurses to ensure orders were processed timely but admitted it was not something she had monitored. R7 R7's face sheet printed on 10/20/22, included diagnoses of urinary tract infection (UTI) and acute pyelonephritis (kidney infection). R7's admission MDS assessment dated 9/19/22, indicated R2 was cognitively intact and required extensive assistance of one staff for most ADLs. R7's care plan dated 9/13/22, indicated R7 had urinary tract infection with antibiotic use, and the UTI would resolve without complication. Staff were to monitor, document and report signs and symptoms of UTI, such as pain, hematuria and altered mental status. Further, the care plan indicated R7 would have a PICC (peripherally			F 755			

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F 755	Continued From page 21 inserted central catheter [a tube inserted into a vein used to give IV fluids and drugs]) line for the purpose of receiving IV (intravenous infusion) antibiotics. R7 was admitted to the facility from a hospital on 9/13/22, with orders from the hospital to administer ertapenem (antibiotic) 1 gram IV every 24 hours for UTI. Prior to leaving the hospital, R7 received a dose of ertapenem and would have been due for the next dose on 9/14/22. During review of the MAR (medication administration record), it was noted the ertapenem had not been started until 9/15/22, causing R7 to miss one dose on 9/14/22. During record review, progress note dated 9/13/22, at 11:45 a.m. indicated R7 was admitted to the facility from a hospital where she had been with pulmonary embolism and UTI, and also had ureteral stents placed. During an interview on 10/20/22, at 10:13 a.m., the administrator stated he was aware of the delay in starting the ertapenem for R7, and stated the DON was responsible for ensuring the IV antibiotic medication was available when R7 was admitted. During an interview on 10/20/22, at 12:01 p.m., the director of nursing (DON) confirmed R7 was to continue ertapenem from the hospital and confirmed by looking in R7's electronic medical record (EMR), that R7 did not receive a dose of ertapenem on 9/14/22. The DON stated any nurse could have arranged the IV antibiotic, then later admitted the DON would be the person to arrange getting an IV medication into the facility. The DON stated she didn't usually get involved	F 755			

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F 755	Continued From page 22 with ordering medications and by the time she got involved, it was too late to get the antibiotic to the facility on time. During an interview on 10/20/22, at 12:25 p.m. with social services (SS)-A and the DON, SS-A provided the original pre-admission packet that had been faxed from the hospital to the facility on 9/6/22, which indicated R7 was to receive ertapenem 1 gram IV every 24 hours for UTI. The DON stated she recalled seeing the order but didn't take action to order it stating there had been no guarantee R7 would still be on the medication when admitted to the facility. In addition, the DON stated she didn't like to order medication too far in advance as the physician order might change. Despite this uncertainty and knowing this was not a typical medication for the facility, the DON admitted she did not contact the hospital to ask if R7 would still be on ertapenem IV every 24 hours when admitted to the facility. R3 R3's face sheet printed on 10/20/22, included diagnoses of cerebral infarction (stroke) with hemiplegia (paralysis on one side of the body), contracture (fixed tightening of muscle, tendons, ligaments or skin) of multiple muscles, pressure ulcer of sacral region and dementia. R3's admission Minimum Data Set (MDS) assessment dated 9/6/22, indicated R3 had severely impaired cognition. R3 did not speak, his hearing was highly impaired, vision was severely impaired and he was rarely/never understood nor did he understand. R3 did not walk and required extensive assistance of two staff for bed mobility and toileting. R3 was totally dependent upon two	F 755			

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F 755	Continued From page 23 staff and a mechanical lift for transfers. R3 had indicators of pain such as non-verbal sounds, facial expression and protective body movements observed on one to two days during the admission MDS assessment. R3's care plan revised on 9/13/22, indicated R3 had the potential for pain related to contractures and pressure ulcers, and would have a decrease in displays of inadequate pain control, such as grimacing. Staff were to observe, record and report signs and symptoms of non-verbal pain such as moaning and restlessness. During record review, on 9/19/22, R3 was seen by nurse practitioner (NP)-C who documented in the visit note, concern about R3's restlessness. NP-C wrote a new order to change Tylenol (a medication used to treat mild to moderate pain) from PRN (as needed), to a scheduled dose of Tylenol four times a day. In addition, Atarax (a medication to treat itching) was ordered. Furthermore, NP-C ordered staff to be watchful for increase symptoms of pain. New orders were as follows; --Tylenol, give 10 ml (milliliter) via g-tube (gastrostomy tube) QID (four times a day) --Atarax 10 mg (milligrams)/5 ml, take 2.5 ml via g-tube BID (twice a day) During review of the MAR, it was noted the new orders for Tylenol and Atarax were not implemented until 9/29/22, 10 days after being ordered. The MAR for September 2022, prior to the start of scheduled Tylenol, indicated R3 was administered PRN Tylenol one time on 9/29/22, at 3:45 a.m. for 4/10 pain. Nursing progress notes	F 755			

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F 755	Continued From page 24 reviewed from admission on 8/31/22, to the new order for scheduled Tylenol on 9/29/22, indicated 11 entries where licensed nursing staff documented R3 was comfortable, no grimacing, or didn't appear to be in pain. During a telephone interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A was unaware of a delay in Tylenol and Atarax being started for R3, adding, "That's one thing they do different there...provider orders are processed by whomever can get to them," and added it was hard to access paper orders once they were signed off as they were kept locked somewhere. RN-A stated R3 had some grimacing during cares, but for the most part did not seem to have pain when assessing his non-verbal cues. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated R3 had always been on Tylenol but it was PRN and had not been given, therefore the order was changed from PRN to scheduled to ensure R3 received something for pain on a regular basis. NP-C stated there had been a concern of increased or unrelieved pain in an individual who couldn't communicate his needs. During an interview on 10/20/22, at 8:35 a.m., nursing assistant (NA)-A stated R3 was repositioned every two hours and that sometimes he appeared to be in pain due to facial grimacing. NA-A stated staff were very careful with him. NA-A stated she had not reported to a nurse that R3 was in pain because once done moving him, he no longer had grimacing. During an interview on 10/20/22, at 9:41 a.m., licensed practical nurse (LPN)-A was aware after the fact of the delay in processing orders for	F 755			

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F 755	Continued From page 25 Tylenol and Atarax for R3. LPN-A explained that in the past, one nurse (the MDS nurse) entered all provider orders into the EMR, and as a result nurses working on the floor were not used to processing orders. When this nurse separated employment, the process for floor nurses to enter orders was not well-defined and as a result, some orders were not processed timely. LPN-A stated he was then moved to day shift charge nurse position in order to provide consistency and to ensure orders were processed timely. In addition, LPN-A stated he created a written process to guide the nurses in processing provider orders and educated staff on the process. The new written process was reviewed. During an interview on 10/20/22, at 12:26 p.m., the DON stated she had not initially been aware of the delay in processing orders for Tylenol and Atarax for R3. The DON stated she discovered this when doing random audits of provider orders and found the orders had not been signed off or entered into the EMR. The DON stated medical doctor (MD)-E had been in the facility that day and had been informed. The DON stated Tylenol had been changed from PRN to scheduled, to ensure R3 received it regularly since he was not able to verbalize the need for pain medication. The DON stated a new process had been implemented to prevent further delays in processing provider orders. Facility policy titled Physician/Practitioner Orders, dated 12/2/21, indicated the purpose was to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders and to provide a procedure that facilitates the timely and accurate processing of physician/practitioner orders.	F 755			

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F 755	Continued From page 26 Accurate processing of physician/practitioner orders was important. The nursing services department had responsibility for processing physician/practitioner orders in a timely and accurate manner. Admission orders and orders received throughout the resident ' s stay were processed and transcribed into Point Click Care (EMR), immediately upon receipt of the order. The orders must be noted by the licensed nurse who has processed the order.	F 755			
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to promptly obtain a chest x-ray for 1 of 1 resident (R2) resulting in delay of treatment for pneumonia. Findings include: R2's facesheet printed on 10/20/22, included admission diagnoses of heart failure, chronic kidney disease, and hypertension (high blood pressure). On 9/21/22, pneumonia was added.	F 777	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance		11/18/22

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F 777	Continued From page 27 R2's admission Minimum Data Set (MDS) assessment dated 8/26/22, indicated moderately impaired cognition. R2 had adequate vision and hearing, unclear speech, was usually understood and could usually understand. R2 required extensive assistance of one or two staff for most activities of daily living. R2's care plan dated 8/22/22, indicated R2 had hypertension and CHF (congestive heart failure) and R2 would remain free from hypertension and complications related to hypertension. Staff would monitor, document and report symptoms such as lethargy (drowsiness and lack of mental alertness), or difficulty breathing. During record review, on 9/12/22, R2 was seen by nurse practitioner (NP)-C. During lung assessment, rhonchi (an abnormal lung sound) was noted and a chest x-ray was ordered. During record review, on 9/20/22, a chest x-ray was obtained on R2 by PPX (Professional Portable X-Ray) and the results indicated pneumonia. During record review, on 9/21/22, R2 was seen by NP-C who learned the chest x-ray that had been ordered on 9/12/22, had not been completed until 9/20/22, eight days after it had been ordered. During a telephone interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A was unaware of a delay in ordering a chest x-ray for R2, adding, "That's one thing they do different there...provider orders are processed by whomever can get to them," and added it was hard to access paper	F 777	with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F777 Radiology/Diagnostic Services Ordered/Notify Results 1. R2 discharged from the facility on 10/5/22. 2. All residents receiving x-ray orders have the potential to be affected. X-ray orders will be transcribed the same day they are received to ensure x-rays are obtained timely. 3. Education on GSS Policy "Physician/Practitioner Orders" will be reviewed by the DON or designee with all nurses by 11/18/22. 4. Audits will be completed for 5 random residents that receive x-ray orders by the Quality Assurance Coordinator or designee three times weekly x 1 month and weekly x 2 months to ensure diagnostic order are transcribed into Point Click Care timely. Audit results will be brought to the monthly QA meeting for further recommendations.		

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F 777	Continued From page 28 orders once they were signed off as they were kept locked somewhere...no way to review them. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated a chest x-ray had been ordered on 9/12/22, because R2 had been gaining weight and had a history of heart failure, adding those individuals tended to also get pneumonia. NP-C stated due to the delay in obtaining the chest x-ray, the antibiotic to treat pneumonia was also delayed. NP-C stated while there was not a negative outcome, untreated pneumonia could cause worsening of heart failure. During an interview on 10/20/22, at 9:41 a.m., licensed practical nurse (LPN)-A was aware after the fact of the delay in processing the chest x-ray for R2. LPN-A explained that in the past, one nurse (the MDS nurse) entered all provider orders into the electronic medical record (EMR), and as a result nurses working on the floor were not used to processing orders. When this nurse separated employment, the process for floor nurses to enter orders was not well-defined and as a result, some orders were not processed timely. LPN-A stated he was then moved to day shift charge nurse position in order to provide consistency and to ensure orders were processed timely. In addition, LPN-A stated he created a written process to guide the nurses in processing provider orders and educated staff on the process. During an interview on 10/20/2022, at 11:25 p.m., the director of nursing (DON) stated she had not initially been aware of the delay in processing the order for the chest x-ray for R2. The DON stated she discovered the chest x-ray order had been	F 777			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245593	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/20/2022
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F 777	Continued From page 29 missed when doing random audits of provider orders. The DON stated the order was missed because, "I don't think the nurses got to the order." The DON stated provider orders were placed in a box at the nurses station for the charge nurse to process, and the order for R2's chest x-ray had not been processed. The DON stated nurses were not supposed to leave their shift until everything was done, including processing new orders. The DON acknowledged she had responsibility for oversight of nurses to ensure orders were processed timely but admitted it was not something she had monitored. Facility policy titled Physician/Practitioner Orders, dated 12/2/21, indicated the purpose was to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders and to provide a procedure that facilitate the timely and accurate processing of physician/practitioner orders. Accurate processing of physician/practitioner orders was important. The nursing services department had responsibility for processing physician/practitioner orders in a timely and accurate manner. Admission orders and orders received throughout the resident's stay were processed and transcribed into Point Click Care (EMR), immediately upon receipt of the order. The orders must be noted by the licensed nurse who has processed the order.	F 777			

Minnesota Department of Health

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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 10/18/22 to 10/20/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

11/11/22

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H55935183C (MN87614) with licensing orders issued at (0265, 0900, 1550). 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 state form.	2 000			

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2 000	Continued From page 2	2 000			
2 265	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. MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the	2 265			11/18/22

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2 265	Continued From page 3 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure provider was notified of a change in condition for 2 of 2 residents (R2 and R6) for weight gain and elevated blood pressure. Findings include: R2 R2's facesheet printed on 10/20/22, included admission diagnoses of heart failure, chronic kidney disease and hypertension (high blood pressure). On 9/21/22, pneumonia was added. R2's admission Minimum Data Set (MDS) assessment dated 8/26/22, indicated moderately impaired cognition. R2 had adequate vision and hearing, unclear speech, was usually understood and could usually understand. R2 required extensive assistance of one or two staff for most activities of daily living. R2's care plan dated 8/22/22, indicated R2 had hypertension and CHF (congestive heart failure) and R2 would remain free from hypertension and complications related to hypertension. Staff would monitor, document and report symptoms such as lethargy (drowsiness and lack of mental alertness), or difficulty breathing. In addition the care plan indicated R2 had renal failure and would have no complications related to fluid overload. Staff were to monitor for changes in mental status and to elevate feet when up in chair	2 265	corrected		

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2 265	Continued From page 4 to prevent dependent edema. The care plan interventions did not include monitoring weight. A provider order dated 8/27/22, indicated daily weights and to notify a physician if R2 gained greater than 2 lbs (pounds) in 24 hours or 5 lbs in 7 days. Monitor for SOB (shortness of breath), bloating and decreased endurance. During record review, a visit note dated 9/19/22, by nurse practitioner (NP)-C indicated R2 was found to have increased weight gain. Current weight had been 143 lbs and admission weight was 136 lbs. In addition, the note indicated R2 had been spending more time in bed and therapy had reported R2 had not been participating as well as she had been. Furthermore, NP-C hand-wrote a note indicating R2 had weight gains greater than 2.5 lbs in 24 hours and there had been no progress note indicating a provider was informed. During record review, weight gains of greater than 2 lbs in 24 hours were: 9/1/22 to 9/2/22: gain of 7 lbs (142 lbs to 149 lbs). 9/5/22 to 9/6/22: gain of 2.5 lbs (142 lbs to 144.5 lbs). 9/13/22 to 9/14/22: gain of 2.5 lbs (141 lbs to 143.5 lbs). 9/15/22 to 9/16/22: gain of 2.5 lbs (140.5 lbs to 143 lbs). During record review, nursing progress notes from 9/1/22, through 9/16/22, did not identify awareness of R2's weight gains. During an interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A stated R2 came in with fluid retention. RN-A could not recall specific orders regarding notifying a provider of R2's	2 265			

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2 265	Continued From page 5 weight increases. RN-A stated if there had been specific orders, she would have followed them and documented it in a progress note. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated she had been concerned about lack of notification of R2's weight gains. NP-C stated she had increased R2's diuretics because R2 had been gaining weight and had a history of heart failure. NP-C stated while there had not been a negative outcome, prolonged fluid overload could cause worsening of heart failure and therefore was important for staff to monitor R2's weight closely and report weight gains to a provider. During an interview on 10/20/22, at 10:41 p.m., licensed practical nurse (LPN)-A stated that the EMR (electronic medical record) triggered a warning with significant weight gains or losses and displayed the alert prominently on EMR when a specific residents record was accessed. When that occurred, LPN-A stated a nurse was supposed to re-weigh the resident, review past weights, check vital signs, and assess lung sounds, then notify a provider. LPN-A was aware of R2 being monitored for weight gain; but not aware of any recent increases. During an interview on 10/20/22, at 12:55 p.m., nursing assistant (NA)-B stated she entered resident weights in the EMR, and the EMR would alert if there was a weight gain or decrease. In that case, the NA would inform a nurse. NA-B stated she had informed nurses in the past of weight gains, but didn't recall for which residents. NA-B stated she would only inform a nurse of a weight gain if a warning came up in the EMR. During an interview on 10/20/22, at 1:15 p.m.,	2 265			

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2 265	Continued From page 6 trained medication aide (TMA)-A stated if a resident had a weight gain, she would get an alert in the EMR and would tell a nurse. TMA-A did not recall informing a nurse of a weight gain for R2. During an interview on 10/20/22, at 1:55 p.m., the director of nursing (DON) stated staff were to report significant increases and decreases in resident weights, but was unaware if there was a policy identifying what would be considered significant, adding it would depend on the resident. The DON stated she expected staff to notify a provider if a resident gained or lost a significant amount of weight or if a provider wrote an order with specific parameters on when to notify them. R6 R6's face sheet printed on 10/20/22, included diagnoses of hypertensive kidney disease and diabetes. R6's quarterly MDS assessment dated 10/2/22, indicated R6 had severely impaired cognition, adequate vision and hearing, clear speech and was sometimes understood. R6 required extensive assistance of one or two staff for activities of daily living. R6's care plan dated 10/15/22, indicated R6 had hypertension. No other information was listed, including interventions. During record review, a visit note dated 9/14/22, by NP-C indicated R6's blood pressures were markedly elevated and there had been no rechecks after medications were given. The note indicated parameters for nursing staff to follow: if	2 265			

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2 265	Continued From page 7 blood pressure was greater than 170 and or diastolic greater than 95, then recheck in 30 minutes making sure R6 was not symptomatic. If symptomatic, a provider would need to be notified. Further, lisinopril (blood pressure medication) 20 mg was changed to the evening, and norvasc (blood pressure medication) 5 mg daily was started. During record review, blood pressures for 9/1/22, through 9/14/22, indicated R6 had multiple instances of an elevated blood pressure with auto-generated warnings noted in the EMR for 11 of the 16 blood pressures noted below, indicating either a systolic high of 139 or diastolic high of 89 had been exceeded. 9/1/22: 166/89 9/2/22: 177/128 9/3/22: 183/102 9/4/22: 148/113 and 166/110 9/5/22: 183/103 9/6/22: 186/102 9/7/22: 190/113 9/8/22: 179/96 9/9/22: 177/105 9/10/22: 163/91 9/11/22: 166/93 9/12/22: 150/94 9/13/22: 149/88 9/14/22: 143/109 and 156/108 During record review from 9/1/22, through 9/14/22, there were no nursing progress notes indicating awareness of the elevated blood pressures, an assessment of R6 for symptoms of elevated blood pressure or notification to a provider. During a telephone interview on 9/19/22, at 7:35 p.m., NP-C stated when R6's blood pressures	2 265			

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2 265	Continued From page 8 were to be significantly elevated, NP-C took the blood pressures to the charge nurse and asked why a provider had not been notified. NP-C pointed out to the nurse (unidentified) that the elevated blood pressures would have automatically triggered a warning in the EMR. The nurse stated she had not been aware of the elevated blood pressures. NP-C stated the risk of untreated hypertension for R6 was hypertensive crisis and heart damage. During an interview on 10/20/22, at 9:41 a.m., LPN-A stated nursing assistants (NA) obtained all of the vital signs, documented them on a paper "vital signs sheet" and also entered them into the EMR. LPN-A stated nurses were to review the vital signs throughout their shift. In addition, NA's were to notify the nurse of elevated blood pressures, but was aware that did not always happen. LPN-A stated the EMR automatically identified abnormal vital signs and it was a clear visual to nurses, but wasn't sure if each nurse looked at the abnormal vital signs. LPN-A was not aware of R6's having elevated blood pressures in September. During an interview on 10/20/22, at 11:55 a.m., the DON stated in regard to an elevated blood pressure, a provider should be notified for "anything extremely off." The DON didn't know if there were blood pressure parameters that would direct a nurse when to notify a provider and was not aware if there was a facility policy addressing this. The DON admitted a provider should be notified for a blood pressure with a diastolic reading over 100, and was not aware of R6 having elevated blood pressures. During an interview on 10/20/22, at 1:15 p.m., trained medication aide (TMA)-A confirmed she	2 265			

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2 265	Continued From page 9 obtained resident vital signs using a vital signs machine. TMA-A stated most resident blood pressures were low. Together looked at the vitals signs sheet and a blood pressure for a random resident indicated 164/84. TMA-A stated it was a little high, but "we know our residents" and TMA-A didn't consider that to be abnormal for this resident, so would not report it to a nurse. During the same interview, TMA-A pointed out a small laminated card attached to the vital signs machine titled Normal ranges for vital signs and which read: If a residents vitals signs are above or below these ranges, please tell a nurse immediately. Blood pressure 90/60 - 120/80. Report to the nurse if the pressure is above 139/89 or below 90/60, or the resident is complaining of lightheadedness, dizziness, blurred vision and/or pulse 60-100, respirations 12-18, temperature 97.8 - 99.1, O2 (oxygen) level anything below 90% report to a nurse. TMA-A read the card and admitted the blood pressure parameter were confusing as they indicated two different parameters, adding she didn't think anyone looked at the card. During an interview on 10/20/21, at 1:55 p.m., the DON was shown a copy of the card attached to the vitals signs machine; was unaware of this card and admitted it did not provide clear guidance to NA's for when to inform a nurse of a blood pressure reading. The DON stated she expected NA's to notify a nurse of elevated blood pressures, but would have to determine the appropriate parameters for that. Further, the DON expected nurses to be aware of elevated blood pressures, to assess the resident for symptoms and to notify a provider. Facility policy titled Vital Signs - Blood Pressure	2 265			

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2 265	Continued From page 10 dated 9/22/22, indicated the steps in obtaining a blood pressure. Facility policy titled Weight and Height dated 9/22/22, indicated staff were to report significant weight changes immediately to a physician. Significant weight change was defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days. The licensed nurse would immediately notify the medical provider regarding any significant weight change. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure physicians/providers are notified of a change in condition or treatment; educate all appropriate staff on the policies and procedures; and, develop monitoring systems to ensure ongoing compliance. The DON and/or designee could take finding to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			
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	2 900			11/18/22

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2 900	Continued From page 11 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 interview and document review, the facility failed to comprehensively assess and reassess to ensure adequate routine monitoring of pressure ulcers was completed and recorded for 1 of 1 residents (R3) reviewed for pressure ulcer care and services. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a	2 900	corrected		

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2 900	Continued From page 12 red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) R3's face sheet printed on 10/20/22, included admission diagnoses of cerebral infarction (stroke) with hemiplegia (paralysis on one side of the body), dementia, diabetes, chronic kidney disease, protein-calorie malnutrition, anemia, contracture of multiple muscles, pressure ulcer of sacral region (located below the lumbar spine and above the tailbone, which is known as the coccyx) - stage 4, pressure ulcer of right heel - unstageable, pressure ulcer of left hip - unstageable. R3's admission Minimum Data Set (MDS) assessment dated 9/6/22, indicated R3 had severely impaired cognition. R3 did not speak, his hearing was highly impaired, vision was severely impaired and he was rarely/never understood nor did he understand. R3 did not walk and required extensive assistance of two staff for bed mobility and toileting. R3 was totally dependent upon two	2 900			

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2 900	Continued From page 13 staff and a mechanical lift for transfers. R3's care plan revised on 9/13/22, indicated R3 had impairment to skin integrity related to malnourishment brought on by CVA (cardiovascular accident, or stroke) and would have no complications related to skin integrity concerns identified upon admission. R3's pressure ulcers would show signs of healing and remain free from infection. Interventions included pressure reducing mattress and heel protectors; repositioning every two hours while in bed or chair. The care plan did not indicate monitoring pressure ulcers for location, size and stage. Braden scale for predicting pressure sore risk indicated R3 had been a high risk and a very high risk for PU development when assessed on 8/31/22, and 10/18/22, respectively. R3 had multiple physician orders for monitoring of the pressure ulcers, but no specific order to measure or stage pressure ulcers. During record review, an admission visit note by medical doctor (MD)-E dated 9/7/22, indicated R3 had a chronic sacral pressure ulcer with chronic osteomyelitis (bone infection). The note indicated R3 had been in the hospital multiple times over the past year with continued decline and was on comfort cares. While the sacral ulcer was mentioned, there were no sacral ulcer measurements included in the note. Further, the note indicated R3 had skin care to buttocks, bilateral heels, coccyx, and left knee. These wounds were not identified as PUs or non-pressure related wounds. During record review, a progress note by nurse practitioner (NP)-C dated 10/5/22, indicated R3's	2 900			

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2 900	Continued From page 14 sacral ulcer to be worsening. No measurement or staging of the sacral ulcer was included in the note. During this visit, photographs were taken of various area of R3's wounds with a tape measure across the wound, but no actual measurements were listed. The reader would need to determine measurements based upon the photos. Over the course of seven weeks (admission on 8/31/22, to 10/19/22), according to wound data collection documents provided by the director of nursing (DON) (unless otherwise indicated), the sacral ulcer was assessed at least six times, however lacked a comprehensive assessment. Documentation as follows: 1. During record review, a note by NP-C dated 9/19/22, indicated the sacral wound measured 3 cm (centimeter) x 2 cm x 2.5 cm, with 3 cm undermining and bone exposure. 2. 9/20/22, at 11:40 p.m., indicated 3 cm in length x 2.5 cm in width x 3 cm in depth. Undermining of 3 cm. Incomplete wound characteristics were documented: moderate sanguineous drainage was documented, but no percentage of various type of tissue healing, e.g., epithelialized, granulation, slough, or eschar. 3. 9/21/22, at 9:50 p.m. No measurements or wound characteristics, only moderate sanguineous drainage was documented. 4. 10/14/22, via progress note by RN-A: 5.0 cm x 3.0 cm x 2 cm. RN-A sent a message to DON to confirm she was aware of increase in size of the sacral PU. 5. 10/16/22, via progress note by RN-A: 5.0 cm x 3.0 cm x 2 cm. The progress note indicated MD-E	2 900			

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2 900	Continued From page 15 was notified with the concern the sacral wound was getting bigger. MD-E replied that is was not getting bigger. 6. 10/19/22, 3:30 p.m. Measurements indicated worsening of the sacral PU: 6.9 cm in length, 4.5 cm in width, no depth or undermining was documented. Epithelialized tissue was 10% and granulated tissue was 90%. Moderate sanguineous drainage. Wound margins were listed as intact, pink and macerated - softened, wrinkled tissue due to moisture. During an interview on 10/18/22, at 4:00 p.m., the director of nursing stated R3 had been living with family who neglected him, and that R3 was admitted to the facility with multiple pressure ulcers. The DON stated the majority of the time, R3's PUs were assessed and measured by NP-C, although some nurses took measurements too. The DON stated the expectation for a comprehensive assessment was weekly, but she didn't hold staff accountable to that because she was new and didn't know for sure how often it should be done. The DON admitted she could have reviewed the PU policy to learn this. The DON stated not all nurses felt comfortable measuring PU's and felt they lacked the competency to measure the more extensive PU on R3's sacrum. The DON acknowledged that in order to determine if a PU was improving or worsening, the PU would need to be assessed weekly with measurements and staging, and a comparison made to previous measurements. The DON admitted this had not been done. The DON was asked to have R3's PU's measured, and to provide documentation of each of R3's PU assessments since admission. Furthermore, the DON stated NP-C who had been doing the majority of R3's PU assessments had stopped	2 900			

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2 900	Continued From page 16 seeing residents at the facility after 10/5/22. A different NP had taken over who did not measure or stage PUs. Despite learning this on 10/4/22, no action had been taken to determine who would perform weekly comprehensive assessments of R3's PU. During an interview on 10/20/22, at 8:35 a.m., nursing assistant (NA)-A stated R3 was repositioned every two hours, but no matter what, R3 always wiggled back onto his back, that he did not like to lay on his side. On 10/20/22, at 12:00 p.m., the DON provided 49 wound data collection forms for R3, for multiple wounds and pressure ulcers in 15 locations dating from 8/31/22, through 10/19/22. The documentation failed to identify whether the wound was a PU or a non-pressure related wound. Documentation failed to show PU assessments were performed weekly until healed. The forms varied in terms of a comprehensive assessment as most lacked measurements and wound characteristics. No PU's were staged. After reviewing all of the forms and interviewing staff (interviews below with LPN-A and NP-C), it was determined the only remaining PU was to the sacrum -- all other wounds either did not fit the description of a PU, and/or had healed. During an interview on 10/20/22, at 1:28 p.m., (NP)-D stated she told the facility on 10/5/22, that she does not do wound management and recommended contacting their corporate office find out how wound management could be accomplished as it was important to have a consistent person assessing the wounds and doing the measurements.	2 900			

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2 900	Continued From page 17 During an interview and observation on 10/20/22, at 1:38 p.m., with licensed practical nurse (LPN)-A, observed dressing changes to R3's sacrum and several other wounds. Sacral ulcer appeared to be approximately 2.5 inches x 2.5 inches. Clean wound edges. Bone of the spine visible. LPN-A stated other than the sacrum, R3 had no other open wounds. R3 was on a pressure relieving mattress. During a telephone interview on 10/20/22, at 2:09 p.m., NP-C confirmed the only wound open right now had been the sacrum. NP-C stated the facility was doing the best they could given R3's weight, nourishment and inability to stay off his sacrum, but someone needed to continue to evaluate and assess R3's PU's regularly to determine worsening or improvement. Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation dated 4/26/22, indicated the purpose was to accurately document observations and assessments of residents. If a pressure ulcer was identified the registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA (i.e., for a PU, record the stage). The licensed nurse recorded the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection UDA. Skin tears, abrasions and bruises were not intended to be recorded on this form. Interdisciplinary team should determine any modifications that were necessary to the residents plan of care. When a PU was present, daily monitoring should occur. The PU should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA. Observations should include:	2 900			

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2 900	Continued From page 18 measurements - length, width, depth, characteristics - including wound bed, undermining, tunneling, exudate, surrounding skin, presence of pain, current treatments. Progress toward healing and modifications to the plan of care/treatments should be assessed and evaluated by the RN. In-services for nursing and other disciplines would be held as necessary and would include: pressure ulcer protocols and guidelines, skin observation and assessments, instruction of accurate documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures related to pressure ulcer assessment, care and treatment and ensure facility staff are educated. The director of nursing or designee, could 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 pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented and documented. The DON and/or designee could take finding to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.	21550			11/18/22

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21550	Continued From page 19 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to promptly process medication orders for 3 of 3 residents (R2, R7 and R3) resulting in a delay in receiving medications prescribed for fluid retention, infection, pain and itching. Findings include: R2 R2's facesheet printed on 10/20/22, included diagnoses of heart failure, chronic kidney disease, and hypertension (high blood pressure). R2's admission Minimum Data Set (MDS) assessment dated 8/26/22, indicated moderately impaired cognition. R2 had adequate vision and hearing, unclear speech, was usually understood and could usually understand. R2 required extensive assistance of one or two staff for most activities of daily living. R2's care plan dated 8/22/22, indicated R2 had hypertension and CHF (congestive heart failure) and R2 would remain free from hypertension and complications related to hypertension. Staff would monitor, document and report symptoms such as lethargy (drowsiness and lack of mental alertness), or difficulty breathing. During record review, a visit note dated 9/19/22, indicated R2 was seen by nurse practitioner	21550	corrected		

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21550	Continued From page 20 (NP)-C and found to have increased weight gain from 136 lbs (pounds) to 143 lbs and was spending more time in bed. NP-C ordered an increase in Lasix (diuretic) to 60 mg daily and ordered metolazone (diuretic) 2.5 mg daily for 3 days. During record review, a visit note dated 9/21/22, indicated R2 was seen by NP-C who discovered the diuretics ordered on 9/19/22, had not been started. During record review, R2's medication administration record (MAR) indicated Lasix 60 mg daily and metolazone 2.5 mg daily for 3 days, were started on 9/21/22, two days after they were ordered. During a telephone interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A was unaware of a delay in starting diuretics for R2 , adding, "That's one thing they do different there...provider orders are processed by whomever can get to them," and added it was hard to access paper orders once they were signed off as they were kept locked somewhere...no way to review them. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated an increase in diuretics had been order because R2 had been gaining weight and had a history of heart failure. NP-C stated while there was not a negative outcome, prolonged fluid overload could cause worsening of heart failure. During an interview on 10/20/22, at 9:41 a.m., licensed practical nurse (LPN)-A was aware after the fact of the delay in processing the chest x-ray for R2. LPN-A explained that in the past, one nurse (the MDS nurse) entered all provider orders	21550			

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21550	Continued From page 21 into the electronic medical record (EMR), and as a result nurses working on the floor were not used to processing orders. When this nurse separated employment, the process for floor nurses to enter orders was not well-defined and as a result, some orders were not processed timely. LPN-A stated he was then moved to day shift charge nurse position in order to provide consistency and to ensure orders were processed timely. In addition, LPN-A stated he created a written process to guide the nurses in processing provider orders and educated staff on the process. The new written process was reviewed. During an interview on 10/20/2022, at 11:25 p.m., the director of nursing (DON) stated she had not initially been aware of the delay in processing the orders for the diuretics for R2. The DON stated she discovered the diuretic order had been missed when doing random audits of provider orders. The DON stated the order was missed because, "I don't think the nurses got to the order." The DON stated provider orders were placed in a box at the nurses station for the charge nurse to process, and the order for R2's diuretics had not been processed timely. The DON stated nurses were not supposed to leave their shift until everything was done, including processing new orders. The DON acknowledged she had responsibility for oversight of nurses to ensure orders were processed timely but admitted it was not something she had monitored. R7 R7's face sheet printed on 10/20/22, included diagnoses of urinary tract infection (UTI) and acute pyelonephritis (kidney infection).	21550			

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21550	Continued From page 22 R7's admission MDS assessment dated 9/19/22, indicated R2 was cognitively intact and required extensive assistance of one staff for most ADLs. R7's care plan dated 9/13/22, indicated R7 had urinary tract infection with antibiotic use, and the UTI would resolve without complication. Staff were to monitor, document and report signs and symptoms of UTI, such as pain, hematuria and altered mental status. Further, the care plan indicated R7 would have a PICC (peripherally inserted central catheter [a tube inserted into a vein used to give IV fluids and drugs]) line for the purpose of receiving IV (intravenous infusion) antibiotics. R7 was admitted to the facility from a hospital on 9/13/22, with orders from the hospital to administer ertapenem (antibiotic) 1 gram IV every 24 hours for UTI. Prior to leaving the hospital, R7 received a dose of ertapenem and would have been due for the next dose on 9/14/22. During review of the MAR (medication administration record), it was noted the ertapenem had not been started until 9/15/22, causing R7 to miss one dose on 9/14/22. During record review, progress note dated 9/13/22, at 11:45 a.m. indicated R7 was admitted to the facility from a hospital where she had been with pulmonary embolism and UTI, and also had ureteral stents placed. During an interview on 10/20/22, at 10:13 a.m., the administrator stated he was aware of the delay in starting the ertapenem for R7, and stated the DON was responsible for ensuring the IV antibiotic medication was available when R7 was admitted.	21550			

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21550	Continued From page 23 During an interview on 10/20/22, at 12:01 p.m., the director of nursing (DON) confirmed R7 was to continue ertapenem from the hospital and confirmed by looking in R7's electronic medical record (EMR), that R7 did not receive a dose of ertapenem on 9/14/22. The DON stated any nurse could have arranged the IV antibiotic, then later admitted the DON would be the person to arrange getting an IV medication into the facility. The DON stated she didn't usually get involved with ordering medications and by the time she got involved, it was too late to get the antibiotic to the facility on time. During an interview on 10/20/22, at 12:25 p.m. with social services (SS)-A and the DON, SS-A provided the original pre-admission packet that had been faxed from the hospital to the facility on 9/6/22, which indicated R7 was to receive ertapenem 1 gram IV every 24 hours for UTI. The DON stated she recalled seeing the order but didn't take action to order it stating there had been no guarantee R7 would still be on the medication when admitted to the facility. In addition, the DON stated she didn't like to order medication too far in advance as the physician order might change. Despite this uncertainty and knowing this was not a typical medication for the facility, the DON admitted she did not contact the hospital to ask if R7 would still be on ertapenem IV every 24 hours when admitted to the facility. R3 R3's face sheet printed on 10/20/22, included diagnoses of cerebral infarction (stroke) with hemiplegia (paralysis on one side of the body), contracture (fixed tightening of muscle, tendons, ligaments or skin) of multiple muscles, pressure	21550			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21550	Continued From page 24 ulcer of sacral region and dementia. R3's admission Minimum Data Set (MDS) assessment dated 9/6/22, indicated R3 had severely impaired cognition. R3 did not speak, his hearing was highly impaired, vision was severely impaired and he was rarely/never understood nor did he understand. R3 did not walk and required extensive assistance of two staff for bed mobility and toileting. R3 was totally dependent upon two staff and a mechanical lift for transfers. R3 had indicators of pain such as non-verbal sounds, facial expression and protective body movements observed on one to two days during the admission MDS assessment. R3's care plan revised on 9/13/22, indicated R3 had the potential for pain related to contractures and pressure ulcers, and would have a decrease in displays of inadequate pain control, such as grimacing. Staff were to observe, record and report signs and symptoms of non-verbal pain such as moaning and restlessness. During record review, on 9/19/22, R3 was seen by nurse practitioner (NP)-C who documented in the visit note, concern about R3's restlessness. NP-C wrote a new order to change Tylenol (a medication used to treat mild to moderate pain) from PRN (as needed), to a scheduled dose of Tylenol four times a day. In addition, Atarax (a medication to treat itching) was ordered. Furthermore, NP-C ordered staff to be watchful for increase symptoms of pain. New orders were as follows; --Tylenol, give 10 ml (milliliter) via g-tube (gastrostomy tube) QID (four times a day) --Atarax 10 mg (milligrams)/5 ml, take 2.5 ml via g-tube BID (twice a day)	21550			

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21550	Continued From page 25 During review of the MAR, it was noted the new orders for Tylenol and Atarax were not implemented until 9/29/22, 10 days after being ordered. The MAR for September 2022, prior to the start of scheduled Tylenol, indicated R3 was administered PRN Tylenol one time on 9/29/22, at 3:45 a.m. for 4/10 pain. Nursing progress notes reviewed from admission on 8/31/22, to the new order for scheduled Tylenol on 9/29/22, indicated 11 entries where licensed nursing staff documented R3 was comfortable, no grimacing, or didn't appear to be in pain. During a telephone interview on 10/19/22, at 3:55 p.m., registered nurse (RN)-A was unaware of a delay in Tylenol and Atarax being started for R3, adding, "That's one thing they do different there...provider orders are processed by whomever can get to them," and added it was hard to access paper orders once they were signed off as they were kept locked somewhere. RN-A stated R3 had some grimacing during cares, but for the most part did not seem to have pain when assessing his non-verbal cues. During a telephone interview on 10/19/22, at 7:35 p.m., NP-C stated R3 had always been on Tylenol but it was PRN and had not been given, therefore the order was changed from PRN to scheduled to ensure R3 received something for pain on a regular basis. NP-C stated there had been a concern of increased or unrelieved pain in an individual who couldn't communicate his needs. During an interview on 10/20/22, at 8:35 a.m., nursing assistant (NA)-A stated R3 was repositioned every two hours and that sometimes he appeared to be in pain due to facial grimacing.	21550			

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21550	Continued From page 26 NA-A stated staff were very careful with him. NA-A stated she had not reported to a nurse that R3 was in pain because once done moving him, he no longer had grimacing. During an interview on 10/20/22, at 9:41 a.m., licensed practical nurse (LPN)-A was aware after the fact of the delay in processing orders for Tylenol and Atarax for R3. LPN-A explained that in the past, one nurse (the MDS nurse) entered all provider orders into the EMR, and as a result nurses working on the floor were not used to processing orders. When this nurse separated employment, the process for floor nurses to enter orders was not well-defined and as a result, some orders were not processed timely. LPN-A stated he was then moved to day shift charge nurse position in order to provide consistency and to ensure orders were processed timely. In addition, LPN-A stated he created a written process to guide the nurses in processing provider orders and educated staff on the process. The new written process was reviewed. During an interview on 10/20/22, at 12:26 p.m., the DON stated she had not initially been aware of the delay in processing orders for Tylenol and Atarax for R3. The DON stated she discovered this when doing random audits of provider orders and found the orders had not been signed off or entered into the EMR. The DON stated medical doctor (MD)-E had been in the facility that day and had been informed. The DON stated Tylenol had been changed from PRN to scheduled, to ensure R3 received it regularly since he was not able to verbalize the need for pain medication. The DON stated a new process had been implemented to prevent further delays in processing provider orders.	21550			

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21550	Continued From page 27 Facility policy titled Physician/Practitioner Orders, dated 12/2/21, indicated the purpose was to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders and to provide a procedure that facilitates the timely and accurate processing of physician/practitioner orders. Accurate processing of physician/practitioner orders was important. The nursing services department had responsibility for processing physician/practitioner orders in a timely and accurate manner. Admission orders and orders received throughout the resident 's stay were processed and transcribed into Point Click Care (EMR), immediately upon receipt of the order. The orders must be noted by the licensed nurse who has processed the order. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about transcribing, ordering medication, pharmacy services and the disposition of the medication, and develop monitoring systems to ensure ongoing compliance. The DON and/or designee could take finding to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550			