Electronically delivered
December 3, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: November 17, 2021

Dear Administrator:

On November 17, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On September 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's

administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Johns On Fountain Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effectiveNovember 17, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 11/17/2021

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ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 000	INITIAL COMMENTS On 11/16/21, through 11/17/21, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The following complaint was SUBSTANTIATED: H5635022C (MN77193) at F678 for PAST NON-COMPLIANCE. The following complaint was found to be SUBSTANTIATED: H5635026C (MN59874), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5635024C (MN73293), and H5635021C (MN77709). Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced	F 678		

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

Electronically Signed

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F 678	Continued From page 1 by: Based on interview and document review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) in accordance with resident wishes and physician orders for 1 of 1 resident (R3) who required emergency care. This deficient practice resulted in an immediate jeopardy (IJ) situation when R3 was found with absent pulse and respirations, and timely CPR was not initiated. The immediate jeopardy began on 9/22/21, at 4:40 a.m. when R3 had no respirations or pulse and CPR was not initiated. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 6:30 p.m. on 11/16/21. The immediate jeopardy was removed, and the facility implemented correction action on 9/30/21, prior to the start of the survey and was therefore issued at past non-compliance. Findings include: R3's Admission Record printed 11/16/21, indicated R3 was admitted to the facility on 9/7/21, for rehab and diagnosis included heart failure, atrial fibrillation. R3's admission Minimum Data Set (MDS) dated 9/13/21, indicated resident was cognitively intact and required partial assistance with activities of daily living. R3's care plan dated 9/16/21, indicated R3 was a full code. R3's Provider Orders for Life-Sustaining Treatment (POLST) dated 9/9/21, indicated if R3 had no pulse and was not breathing, staff were	F 678	Past noncompliance: no plan of correction required.	

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F 678	Continued From page 2	F 678		

directed to attempt resuscitation/CPR including the provision of full life sustaining treatment including intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. The POLST was signed on 9/9/21, by R3, a facility representative, and physician.

R3's physician orders dated 9/7/21, indicated CPR/POLST on file.

Progress note dated 9/22/21, at 6:45 a.m. by licensed practical nurse (LPN)-A indicated R3 was found deceased in bed at 4:40 a.m. and death was verified by registered nurse (RN)-A. At 5:00 a.m. family member (FM)-A was notified R3 was deceased. R3's clinical record lacked documentation as to when R3 was last checked or provided care by the nursing staff and lacked documented evidence that CPR had been initiated per R3's identified wishes.

On 11/16/21, at 12:57 p.m. during a phone interview with nursing assistant (NA)-A stated during her shift on 9/22/21, at approximately 4:45 a.m. LPN-A indicated R3 passed away and requested her to confirm. NA-A stated she went into R3's room and R3's chest was not rising up and down and indicated R3 was not breathing, however NA-A stated she had never witnessed a resident that was not breathing. NA-A stated LPN-A then alerted RN-A. RN-A went to R3's room and RN-A and LPN-A indicated they did not feel comfortable with CPR due the unknown time R3 stopped breathing.

On 11/16/21, at 1:13 p.m. during a phone interview with RN-A stated she was the nurse on

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the third floor on 9/22/21 and was not R3's nurse and indicated R3's room was on second floor. RN-A indicated on 9/22/21, at approximately 5:00 a.m. she received a phone call from LPN-A to confirm a death on second floor, RN-A indicated she proceeded to second floor and found LPN-A at the nurse station. RN-A asked LPN-A if R3 had an order to perform CPR or if she was on hospice and LPN-A responded, she didn't know. RN-A indicated R3's computer record indicated CPR, and at that time she informed LPN-A we needed to get to R3's room . RN-A stated when her and LPN-A entered R3's room, R3's arms, upper torso and face were white, and she was cold to the touch. RN-A indicated to LPN-A CPR needed to be started, and then LPN-A indicated about twenty minutes of time had elapsed when R3 was found without a pulse. RN-A stated the facility policy at the time was 4-6 minutes after finding a resident pulseless don't start CPR. RN-A stated she called FM-A and told him R3 was breathless and pulseless, and RN-A to indicated to FM-A staff could start CPR, however FM-A requested CPR not started and to let her [R3] rest. RN-A stated after the incident she received re-education about the policy and refresher course on CPR and stated she would start CPR, if a resident was a full code.

On 11/16/21, at 2:55 p.m. during an interview with the DON stated her investigation into the incident began on 9/27/21, when RN-B notified her R3 was a full code and had not received CPR on 9/22/21, and the DON stated she immediately begun an investigation and filed a vulnerable adult report. The DON investigation indicated:
- 3:00 a.m. R3 call light was on and licensed practical nurse (LPN)-A went into R3's room and sat with her until she fell asleep

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F 678	Continued From page 4 - 3:45 a.m.- 4:00 a.m. nursing assistant (NA)-A checked on resident and found her sleeping. - 4:46 a.m. LPN-A went to R3's room to bring her medications and found R3 pulseless and unresponsive, and LPN-A went and found NA-A assistant and returned to R3's room and assessed R3 again and R3 was unsuccessful for signs of life. There was no indication that CPR was initiated at this time. - 5:00 a.m. registered nurse (RN)-A stated she received a phone call from LPN-A to confirm a death on second floor, RN-A, and asked LPN-A if R3 had an order to perform CPR or if she was on hospice. LPN-A responded that she didn't know. RN-A found a POLST in R3's chart that indicated an order to perform CPR. -The DON identified R3 was a full code and CPR was not initiated when she was found without a pulse. The DON indicated LPN-A should have called for help and should have initiated CPR after determining R3 had no pulse or respirations per R3's CPR order. On 11/16/21, at 4:27 p.m. the DON indicated all active working nursing were provided staff education that started on 9/28/21, and was completed by 9/30/21, education was provided on the CPR policy and procedure and included staff would call for assistance during a medical emergency, initiate CPR when indicated, review of the updated CPR standing orders, and competency quiz. The DON provided a spreadsheet and indicated active working staff completed the education as of 9/30/21. The DON indicated active working staff were educated by their next scheduled shift, causal or leave of absence staff had been contacted to receive training before they next scheduled shift.	F 678		

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On 11/16/21, at 3:36 p.m. during a phone interview with FM-A, stated the facility called him on 9/221/21, at 5:00 a.m. and stated when nursing staff woke her [R3] for her pills she was unresponsive, and staff asked if FM-A wanted CPR and he refused CPR for R3.

On 11/17/21, at 7:52 a.m. an interview via telephone with LPN-A stated on 9/22/21, whom was the nurse responsible for R3 when found unresponsive. LPN-A stated on 9/22/21, she started her shift around 10:45 p.m. and received nurse report, including R3 had increased weakness. LPN indicated at about 12:00 a.m. R3's call light was on and LPN-A entered R3's room and R3 indicated she said she didn't need anything. LPN-A stated she sat with R3 until she fell asleep. LPN-A stated she was on break from approximately 4:00 a.m. to 4:40 a.m. and entered R3's room after her break with R3's scheduled pain medication. LPN-A stated at that time R3 was in found laying bed, pale in color, and she called R3's name with no response, shook her [R3] with no response, and used two fingers on the neck and wrist and checked R3's pulse and no pulse was felt. LPN-A stated at that time she alerted NA-A she thought R3 had passed away and called RN-A on her Walkie and told RN-A, that R3 was unresponsive. LPN-A stated then she went to the nursing station to check the code status and confirmed the code was CPR. LPN-A indicated she went with RN-A to R3's room to start CPR and she observed RN-A use a stethoscope to check a pulse at the heart location and felt and observed R3's with stiff arm joints and muscles and discoloration of skin of the lower legs with, "reddish, bluish, purplish" color, skin was not warm, and cool to touch. LPN-A indicated with the observations RN-A and herself

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made of R3, they decided CPR was not advisable . RN-A called FM-A, and he refused CPR. LPN-A stated she provided information to her nurse manger on the morning of 9/22/21, of the incident. LPN-A verified 911 was not called, and confirmed CPR was not initiated. LPN-A further indicated R3 was a new resident at the facility, and was not aware of R3's code status prior to her shift. LPN-A stated she received education after the incident regarding call 911 right away and would confirm code and would start CPR. LPN-A stated with the facility education she recently received she would have performed CPR on the resident and verbalized understanding of the facility education provided on CPR and code status.

Review of the facility memo dated 9/29/21, indicated the facility requested licensed nursing staff were expected to complete education on the CPR Policy and Procedure and the skills assessment questionnaire by 9/30/21, and prior to working on the units; the memo further indicated upon completion staff signature showed understanding.

Review of the sign in sheet titled, What If a Resident is Found Unresponsive dated 9/29/21, and 9/30/21, indicated staff signatures acknowledged review of the education.

On 11/16/21, at 9:26 a.m. NA-B stated she would call for the nurse if she found a resident unresponsive and the nurse would direct actions to be taken and indicated the code status would be determined by the resident's chart.

On 11/16/21 , at 9:40 a.m. NA-C stated if a resident was found unresponsive would call for a

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nurse right away and then look in their chart for code status and take direction from the nurse.

On 11/16/21, at 1:40 p.m. LPN-B stated in the event of a medical emergency, she would call for help, look in the chart for the resident code status, if CPR would send NA for defibrillator, call 911, and would start CPR. LPN-B reiterated that if a resident status was CPR, she would start CPR right away.

On 11/16/21, at 1:47 p.m. RN-D indicated a resident's code status was in the chart, and if she found a resident unresponsive, she would assess patient, check code status, and if not breathing and full code she would start CPR.

On 11/16/21 at 2:46 p.m. LPN-C stated in the event a resident was found unresponsive, the nurse was supposed to assess the resident, and if a full code, start chest compressions, start CPR. RN-B stated the code status information was in the resident chart, and indicated if he couldn't determine how long resident without pulse/breathing at time of assessment CPR would be initiated

Policy titled St John's Lutheran Community CPR Policy dated 9/21, indicated:
-It is the policy that this facility will provide basic life support including CPR- cardiopulmonary resuscitation, when a resident requires such emergency care, prior to the arrival of the emergency medical services, subject physician order and resident choice indicated in the resident's advance directives .
Procedure:
1. CPR certified staff will be available at all times and maintain current CPR certification for

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F 678	Continued From page 8 health care providers 2. Upon admission, all residents/families will be notified the facilities unwitnessed CPR policy 3. Staff will obtain signature on the POLST form. 4. Resuscitation (CPR) will be provided to residents that have indicated they want CPR or have not chosen an advance directive. 5. Staff present will notify the charge nurse. Resuscitation efforts will be immediately be started by the CPR certified staff unless obvious signs of clinical irreversible death are president such as rigor mortis, dependent lividity, decapitation , transaction, decomposition if initiating CPR could cause injury or peril to the rescuer 6. 911 will be called 7. The resident's family will be notified 8. The physician will be notified Policy titled St John's Lutheran Community CPR procedure, dated 9/21 indicated Procedure: 2. Check for resident response 3. Assess the resident for breathing and pulse for 10 seconds 4. Shout for nearby help or use the call light system for assistance activate the emergency response system, staff are immediately instructed to retrieve AED in emergency equipment. 5. Either the staff member who found the resident or responding staff member is to notify residents nurse of event and verify CPR or DNR status ASAP. If resident has a valid advance directive or do not resuscitate order do not perform CPR 6. If DNR order or advanced directive exists and if the advance directive does not indicate do not resuscitate began CPR	F 678		

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F 678	Continued From page 9 The past noncompliance immediate jeopardy began on 9/22/21. The immediate jeopardy was removed and the deficient practice corrected by 10/1/21, after the facility implemented a systemic plan that included the following actions: education provided to nursing staff on all floors of CPR policy and procedures, review and nursing staff education of nurse job description, revised the CPR policy and procedure, review of CMS Clarifies CPR Policy for Nursing homes, staff education on revised standing orders, education where to access resident code status, steps to take for an unresponsive resident, and staff competency quiz regarding procedure when finding a resident unresponsive and where to locate resident code status forms, Additionally, the facility removed the statement in the policy that stated "and not on those known to have been clinically dead for more than four to six minutes."	F 678		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 3, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: Event ID: 3I0P11

Dear Administrator:

The above facility survey was completed on November 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00138	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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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 11/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5338064C (MN70122) with a licensing order issued. The following complaints were found to be UNSUBSTANTIATED: H5338063C (MN71232) H5338062C (MN71472) H5338061C (MN78508) 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	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	2 265		12/29/21

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2 265	Continued From page 3 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 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician in a timely manner of a significant change for 1 of 1 resident (R3) who fell, sustaining rib fractures. Findings include: R3's face sheet printed 11/17/21, indicated diagnoses of multiple fractures of ribs on the left side, and history of falling and muscle weakness. R3's quarterly Minimum Data Set (MDS) assessment, dated 12/16/20, indicated R3 had intact cognition, adequate vision and hearing, clear speech, understood others and was able to make herself understood. R3 was independent with bed mobility, required limited assistance of one staff when transferring from bed to wheelchair and walking in her room, and required extensive assistance of one staff for toileting. On 8/12/19, R3's plan of care indicated R3 was a fall risk due to impaired mobility related to physical impairment, weakness and history of falls. A subsequent goal identified R3 would not fall or injure herself. Interventions included: call light in reach, environment free of obstacles, bed in low position, frequent checks for positioning,	2 265	Systemic change Change of Condition policy was updated to include definitions and examples or short-term change of conditions and significant change of conditions. Nurse meetings will be held on 12/20/21 and 12/22/21 to review the change in policy and re-educate on change of condition notification. Nurses who are unable to attend the meeting will be given the information by 12/31/21. A phone list with the attending physicians/NPs, on call physicians/NP, and fax numbers has been created and posted in the nurses offices. Monitor deficient practice The Administrator, Director of Nursing, and Social Services designee will review and initial the 24 hour reports for any change of statuses to ensure they are followed up on timely and correctly. This practice will continue for three months, or longer if needed. Medical records receives 24 hours reports and will ensure the Administrator, Director of Nursing, and Social Services designee reviewed and initialed. Completion date 12/29/2021	

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proper shoe gear and floor mat by bed and chair.

R3's physician orders dated 6/19/20, indicated R3 received Tylenol ES (extra strength), two tablets twice a day for pain or fever. R3 also had order for Tylenol ES, two tablets daily PRN (as needed).

A fall risk assessment conducted on 12/15/20, indicated R3 was a high fall risk.

R3's post fall investigation report dated 2/13/21 at 7:08 a.m. indicated a fall occurred when R3 attempted to ambulate to the bathroom on her own. A new intervention was added to offer assistance with toileting at the beginning of the day shift or end of overnight shift if R3 was awake.

Progress note dated 2/13/21, at 7:03 a.m., by registered nurse (RN)-A indicated that at 6:24 a.m., staff heard a noise and went to check on R3 and found her lying on the floor mid-way between her recliner and the bathroom. R3 told staff she was going to the bathroom, lost her balance and fell. R3 denied pain and was assisted to her recliner using a mechanical lift. Prior to the fall, at approximately 5:00 a.m., R3 had been seen ambulating in her room using her walker and was reminded to use her call light for assistance.

Progress note dated 2/13/21, at 5:09 p.m. by licensed practical nurse (LPN)-A, indicated R3 had left sided pain and told LPN-A, "I think my ribs are broken." Tylenol had been given for pain prior to this at 4:15 p.m. LPN-A palpated the area of pain and noted R3 grimaced with pain in her left mid-back area. No redness, discoloration or deformity was observed.

Progress note dated 2/13/21, at 5:12 p.m., by

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LPN-A indicated R3's family member (FM)-B had been called and updated on R3's condition. FM-B stated "if Tylenol doesn't help, I might want her to go to the ER (emergency room)." LPN-A placed a call to certified nurse practitioner (CNP)-A, but was not able to reach him. There was no indication in the progress notes that a message was left, or if LPN-A attempted to reach CNP-A later, or if another provider was contacted.

Progress note dated 2/14/21, at 6:51 a.m., by (RN)-B indicated R3 was actively moving about in bed during the night independently, and at times looked like R3's left side was hurting per her facial expression.

Progress note dated 2/14/21, at 9:31 p.m., by LPN-A indicated R3 had been seen in her room many times self-transferring and ambulating with and without her walker. R3 was reminded to use call light for assistance. R3 reported her left side hurt but she was seen leaning from her wheelchair or edge of bed; bending and stretching without grimacing or complaints.

Progress note dated 2/15/21, at 1:25 p.m. by (LPN)-B indicated R3 had pain to her left ribs with palpation, but did not flinch or complain of pain at that point. FM-B was present and questioned if R3 needed an xray. LPN-B noted she would contact the physician to update him and see what he recommended.

Progress note dated 2/15/21, at 3:26 p.m., health unit coordinator (HUC)-C indicated a telephone order was received from the physician to get a chest xray by PPX (Professional Portable X-Ray) for left rib pain.

Progress note dated 2/15/21, 9:10 p.m., (LPN)-D

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indicated R3 had been moving about in her room when staff was not around and was reminded to ask for assistance. R3 complained of left rib pain with lifting her arms and sudden movements.

Progress note dated 2/16/21, at 12:22 a.m. by RN-A indicated R3 had been moaning with each movement, and reported pain in left, lateral abdominal area. Tylenol was given for pain.

R3's medication administration record from 2/13 to 2/17/21, R3 rated her pain between 3 and 7/10, and received PRN doses of Tylenol ES on 2/13/21, at 4:27 p.m. for 8/10 pain in left side and back, and on 2/16/21, at 12:21 a.m., for moaning when attempted to change position and pain in left lateral abdominal area. Pain score was documented as unknown. Both doses were documented as being effective for pain.

R3's radiology report from PPX indicated R3's xray was completed on 2/16/21, at 12:55 p.m. At 3:26 p.m., the report was electronically signed by a PPX physician with the results: acute (sudden onset) fractures of the left 8th and 9th ribs noted.

Progress note dated 2/16/21, at 2:01 p.m. by (LPN)-C indicated R3 complained of left sided pain when sitting.

Progress note dated 2/16/21, at 11:04 p.m., (RN)-C indicated xray findings revealed acute fractures of left 8th and 9th ribs.

Progress note date 2/17/21, at 8:25 a.m. by LPN-C indicated FM-B was notified of xray results.

Progress note dated 2/17/21, at 1:51 p.m., by LPN-C indicated the physician was updated with

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xray results and an order was received for lidocaine patch to left rib area daily. FM-B was updated.

Progress note on 2/17/21, at 6:50 p.m., by RN-C indicated R3 was placed on two assist with transfers due to recent fall.

Progress note on 2/18/21, at 7:35 p.m., by RN-C indicated R3's rib pain was relieved by lidocaine and scheduled acetaminophen (generic name for Tylenol).

During a telephone interview on 11/17/21, at 12:51 p.m., her progress notes from 2/13 and 2/14/21 were read to (LPN)-A. When asked if she recalled why she called certified nurse practitioner (CNP)-A, LPN-A stated she probably called him because R3 was having pain and to get an order for an xray if FM-B wanted to do that. LPN-A added that CNP-A did not always answer, adding if it would have been emergent she would have called the hospital -- "I didn't feel it was an emergency because although R3 was having some pain, she was moving about freely." LPN-A stated she didn't recall if she left CNP-A a phone message and stated if she didn't document that she tried calling him again, she probably did not.

During an interview on 11/17/21, at 1:08 p.m. R3 was in her room in her wheelchair. R3 did not recall a fall where she broke her ribs, adding FM-B might remember and could be contacted.

During an interview on 11/17/21, at 1:14 p.m. director of nursing (DON) was asked to review R3's progress notes from 2/13 to 2/17/21. After reading them, the DON was asked if anything stood out to her. The DON stated, "Just that they should have contacted a physician about the rib

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pain. They kept noting it, but did nothing." The DON stated she would have expected LPN-A to keep trying to reach CNP-A, "She should have perused it further" and added that LPN-A should have called again the following day when she worked. Looking at the progress notes, the DON stated LPN-B who was a full time nurse, should have followed up on R3's pain to determine if the provider had been notified. The DON could not think of a reason staff would not call a provider...."They should have called, and if they were having problems reaching a provider, they could have called me and I would provide direction." When asked if she felt R3 received care in a timely manner for her rib pain following a fall on 2/13, the DON stated she did not feel R3 received care in a timely manner. The DON admitted this was the first she had heard of this delay in care. The DON stated that the administrator, the social worker and her check "IPN" notes (progress notes) each morning; but could not speak to how the delay was missed, adding, "I can't recall why at this point, but it appears the delay was missed." When asked how it was that the physician was first notified of the xray result more than 24 hours after the results were available to the facility, the DON stated the provider would have received notification of the results too, although she didn't know how that process occurred. "He has responsibility for a lot of nursing homes -- that could be the reason for the delay." The DON reiterated that the LPN-A should have left a message for CNP-A, called him again, called another provider, or let her or the administrator know. "They need to use their clinical decision making skills." The DON added that the nurses probably were not reading prior progress notes to be aware of R3 having continued pain and didn't relay the report of pain to the next shift.

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2 265	Continued From page 9 On 11/17/21, at 2:35 p.m., a call was placed to FM-B and message left. During an interview on 11/17/21, at 2:52 p.m. the administrator stated she because aware of this fall today, as well as the perceived delay of care. The administrator stated FM-B told the staff that if Tylenol didn't work, she might want R3 to go to the ER. The administrator stated she felt the Tylenol had been working, but admitted the staff continued to document that R3 was having pain. When asked if she would expect a physician to be notified after a fall in which a resident had pain, the administrator stated she did expect staff to inform a provider, adding she didn't know if LPN-A left a message, or tried again as it had not been documented. During a telephone interview on 11/17/21, at 4:46 p.m. FM-B stated she recalled her mother's fall from February where she sustained broken ribs. FM-B admitted being concerned that it wasn't until she suggested it, that an x-ray was obtained despite R3 complaining of pain for several days. "It wasn't until I said something that they got an X-ray." Facility policy titled Fall Assessing and Reporting, with revised date of 8/19, indicated that after a resident fell, the primary care provider or nurse practitioner would be notified of the fall. Facility policy titled Change of Condition-Resident Physician/NP (nurse practitioner) Notification Policy, dated 11/2000, indicated the attending physician/NP or physician/NP on-call would be notified of changes in a residents condition or health status. The procedure was outlined which included notifying the providers, nurse manager	2 265		

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2 265	Continued From page 10 and DON. Staff were to document the time of the call, the reason and the results or orders received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop/revise and implement policies and procedures to assure the resident's physician is notified of significant change in a resident's condition timely and/or the need to alter treatment, and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		