DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2021

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: July 20, 2021

Dear Administrator:

On October 15, 2021, we notified you a remedy was imposed. On November 2, 2021 the Minnesota Departments of Health and Public Safety 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 October 28, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 20, 2021. be discontinued as of October 28, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 15, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 20, 2021.

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,

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

Electronically delivered
August 4, 2021

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: July 20, 2021

Dear Administrator:

On July 20, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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" tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 20, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 20, 2022 (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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/19/21, through 7/20/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5637015C (MN00074688), with a deficiency cited at F686. H5637016C (MN00074553), however, no deficiencies were cited due to corrective actions taken by the facility. 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 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a 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	F 686		8/24/21

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

Electronically Signed | 08/12/2021

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 686	Continued From page 1 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer timely repositioning and provide a pressure relieving mattress for 1 of 3 residents (R1) who were at risk for pressure ulcer development. Findings include: R1's Face Sheet dated 7/20/21, indicated R1 had diagnoses which included femur fracture, right sided hemiplegia (weakness), aphasia (difficulty speaking), and cerebral infarction (stroke). R1's 5 day prospective payment system Minimum Data Set (MDS) dated 7/9/21, indicated R1 had severe cognitive impairment and required extensive assistance with bed mobility and transfers. R1's MDS also indicated R1 had a state one pressure ulcers with application of ointment/medications. R1's skin Care Area Assessment (CAA) dated 1/20/21, indicated R1 was at risk for pressure injury and had a reddened coccyx upon admission. R1's physician orders dated 7/11/21, indicated R1 had daily monitoring of a stage one coccyx pressure wound. R1's care plan dated 7/9/21, indicated R1 had	F 686	Resident 1□s Stage 1 pressure injury was healed on 7/29/21. An air mattress was placed on R1□s bed on 7/20/21. Family requested the air mattress be removed from R1□s bed on 7/21/21 after discussing the risks/benefits related to falls from bed with the air mattress in place. R1 currently has a pressure reducing mattress on his bed, which is deemed appropriate. R1□s care plan was reviewed and updated to meet current needs. Residents assessed to have current pressure injuries have been evaluated for proper mattresses and have had their repositioning schedules reviewed and deemed appropriate. Care plans have been updated to meet current needs. Facility audit will be completed on all residents to ensure mattresses and repositioning schedules are appropriate to meet resident assessed needs and care plans will be reviewed and updated to ensure accuracy. Policies related to Management of Pressure Injuries and Repositioning have been reviewed and deemed current. Full Time and Part Time RN's, LPN's and Resident Assistants will receive education on Management of Pressure Injuries and Repositioning and following the resident	

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F 686	Continued From page 2 limited physical mobility and was at risk for pressure injury related to right sided hemiparesis and a severe cognitive impairment. R1 required assistance of two staff to reposition in bed. Further, R1 was not able to reliably request assistance and required a pressure reducing mattress/wheelchair cushion. R1 also was to be repositioned every two to three hours. R1's nursing assistant task sheet dated 7/20/21, indicated R1 had a stage one pressure sore on their coccyx and required repositioning every two to three hours. A progress note dated 7/5/21, at 6:35 p.m. indicated R1 was transferred back to the facility from the hospital. The progress note further indicated R1 needed an air mattress due to the coccyx wound. A skin assessment dated 7/19/21, indicated R1's coccyx had a stage one pressure injury and non-blanchable redness. On 7/19/21, during continuous observation from 9:30 to 1:23 p.m R1 was in his room, seated in a wheelchair, and watched television. R1's bed lacked a pressure relieving mattress. At 10:21 a.m. registered nurse (RN)-A entered R1's room with maintenance staff to assist with a bed issue. RN-A exited R1's room at 10:22 a.m. without offering R1 repositioning. At 11:30 a.m. R1 was in their room, still in the wheelchair when another resident visited. At 11:40 a.m. nursing assistant (NA)-A entered R1's room and assisted R1 with their shoes. NA-A exited the room without offering repositioning to R1. At 11:46 a.m. RN-A entered R1's room and obtained a blood glucose reading. R1 was then wheeled to the dining room for lunch	F 686	plan of care by 8/24/21. On-call staff will be educated prior to the start of their next shift. Repositioning audits will be completed weekly on all shifts x 4 weeks to monitor compliance. Audit results will be reported to the QAPI Committee. Clinical Administrator and/or their designee is responsible for monitoring compliance. Completion Date: 8/24/21	

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F 686	Continued From page 3	F 686		

by RN-A. At 12:40 p.m. when R1 finished their meal NA-A wheeled R1 back to their room and left without offering repositioning. At 1:00 p.m. R1's family arrived to visit. At 1:23 p.m. NA-A entered R1's room and assisted R1 to the bathroom using an EZ stand (mechanical lift). At this time, R1's skin was assessed by RN-A. A tegaderm dressing was noted on R1's coccyx. The skin under the tegaderm was noted to be intact with three centimeters of blanchable redness and wrinkle indentations. Three hours and 53 minutes had passed before R1 was repositioned.

In an interview on 7/19/21, at 2:05 p.m. NA-A stated R1 was transferred to their wheelchair before breakfast. NA-A stated R1's repositioning frequency was identified on a nursing assistant task sheet and verified R1 required repositioning every two to three hours.

In an interview on 7/19/21, at 2:10 p.m. RN-A stated R1 was up in his wheelchair for breakfast and in the dining room around 8:30 a.m. RN-A was not aware of repositioning being offered since that time. RN-A stated R1 had a pressure injury and skin prep and tegaderm was being used. RN-A stated R1 was repositioned by offloading with an EZ stand or transferring to bed. RN-A stated R1 needed to be repositioned every two to three hours and R1 had went too long without off-loading pressure.

In an interview on 7/20/21, at 10:05 a.m. RN-B verified R1 did not have a pressure reducing mattress in-place and was unsure if R1 needed one. RN-B stated if the facility lacked an air mattress a supplier was to be notified for a rental. RN-B stated if clinical coordinator called the

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F 686	Continued From page 4	F 686		

rental company a mattress would be delivered the same day.

In an interview on 7/20/21, at 10:40 a.m. RN-C stated staff were expected to follow a resident's care plan and R1 needed to be repositioned every two to three hours. RN-C stated if staff were unable to reposition a resident a nurse needed to be notified. RN-C stated pressure reducing mattresses came from a medical equipment company and a provider order was not needed. RN-C stated a pressure reducing mattress would arrive within 12 hours when requested. RN-C stated any member of the nursing staff were able to order a pressure reducing mattress. At 11:39 a.m. RN-C verified R1's care plan identified a pressure relieving mattress but was unsure why. RN-C stated ordering the air mattress was "likely missed." At 12:08 p.m. RN-C verified the medical supplier never received a request for a pressure reliving mattress for R1.

In an interview on 7/20/21, the director of nursing (DON) stated staff were expected to follow a resident's care plan and nursing assistant task sheet. The DON stated an order for a pressure relieving mattress should be placed within 24 hours.

A facility policy titled Skin Integrity Management modified 6/2021, directed to implement preventative measures and to provide appropriate treatment for residents whose conditions increase their risk for skin injury.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2021

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

Re: State Nursing Home Licensing Orders
Event ID: EYUY11

Dear Administrator:

The above facility was surveyed on July 19, 2021 through July 20, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/19/21, through 7/20/21, 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		

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

Electronically Signed | 08/12/21

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5637015C (MN00074688), with a licensing order issued at 0905. H5637016C (MN00074553), however, no licening orders were issued due to corrective actions taken by the facility. 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	2 000		

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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
2 000	Continued From page 2 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		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer timely repositioning and provide a pressure relieving mattress for 1 of 3 residents (R1) who were at risk for pressure ulcer development. Findings include: R1's Face Sheet dated 7/20/21, indicated R1 had diagnoses which included femur fracture, right sided hemiplegia (weakness), aphasia (difficulty speaking), and cerebral infarction (stroke).	2 905	Corrected	8/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33301	A. BUILDING: _____ B. WING _____	C 07/20/2021

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2 905	Continued From page 3 R1's 5 day prospective payment system Minimum Data Set (MDS) dated 7/9/21, indicated R1 had severe cognitive impairment and required extensive assistance with bed mobility and transfers. R1's MDS also indicated R1 had a state one pressure ulcers with application of ointment/medications. R1's skin Care Area Assessment (CAA) dated 1/20/21, indicated R1 was at risk for pressure injury and had a reddened coccyx upon admission. R1's physician orders dated 7/11/21, indicated R1 had daily monitoring of a stage one coccyx pressure wound. R1's care plan dated 7/9/21, indicated R1 had limited physical mobility and was at risk for pressure injury related to right sided hemiparesis and a severe cognitive impairment. R1 required assistance of two staff to reposition in bed. Further, R1 was not able to reliably request assistance and required a pressure reducing mattress/wheelchair cushion. R1 also was to be repositioned every two to three hours. R1's nursing assistant task sheet dated 7/20/21, indicated R1 had a stage one pressure sore on their coccyx and required repositioning every two to three hours. A progress note dated 7/5/21, at 6:35 p.m. indicated R1 was transferred back to the facility from the hospital. The progress note further indicated R1 needed an air mattress due to the coccyx wound. A skin assessment dated 7/19/21, indicated R1's coccyx had a stage one pressure injury and	2 905		

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2 905	Continued From page 4 non-blanchable redness. On 7/19/21, during continuous observation from 9:30 to 1:23 p.m R1 was in his room, seated in a wheelchair, and watched television. R1's bed lacked a pressure relieving mattress. At 10:21 a.m. registered nurse (RN)-A entered R1's room with maintenance staff to assist with a bed issue. RN-A exited R1's room at 10:22 a.m. without offering R1 repositioning. At 11:30 a.m. R1 was in their room, still in the wheelchair when another resident visited. At 11:40 a.m. nursing assistant (NA)-A entered R1's room and assisted R1 with their shoes. NA-A exited the room without offering repositioning to R1. At 11:46 a.m. RN-A entered R1's room and obtained a blood glucose reading. R1 was then wheeled to the dining room for lunch by RN-A. At 12:40 p.m. when R1 finished their meal NA-A wheeled R1 back to their room and left without offering repositioning. At 1:00 p.m. R1's family arrived to visit. At 1:23 p.m. NA-A entered R1's room and assisted R1 to the bathroom using an EZ stand (mechanical lift). At this time, R1's skin was assessed by RN-A. A tegaderm dressing was noted on R1's coccyx. The skin under the tegaderm was noted to be intact with three centimeters of blanchable redness and wrinkle indentations. Three hours and 53 minutes had passed before R1 was repositioned. In an interview on 7/19/21, at 2:05 p.m. NA-A stated R1 was transferred to their wheelchair before breakfast. NA-A stated R1's repositioning frequency was identified on a nursing assistant task sheet and verified R1 required repositioning every two to three hours. In an interview on 7/19/21, at 2:10 p.m. RN-A stated R1 was up in his wheelchair for breakfast	2 905		

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2 905	Continued From page 5	2 905		

and in the dining room around 8:30 a.m. RN-A was not aware of repositioning being offered since that time. RN-A stated R1 had a pressure injury and skin prep and tegaderm was being used. RN-A stated R1 was repositioned by offloading with an EZ stand or transferring to bed. RN-A stated R1 needed to be repositioned every two to three hours and R1 had went too long without off-loading pressure.

In an interview on 7/20/21, at 10:05 a.m. RN-B verified R1 did not have a pressure reducing mattress in-place and was unsure if R1 needed one. RN-B stated if the facility lacked an air mattress a supplier was to be notified for a rental. RN-B stated if clinical coordinator called the rental company a mattress would be delivered the same day.

In an interview on 7/20/21, at 10:40 a.m. RN-C stated staff were expected to follow a resident's care plan and R1 needed to be repositioned every two to three hours. RN-C stated if staff were unable to reposition a resident a nurse needed to be notified. RN-C stated pressure reducing mattresses came from a medical equipment company and a provider order was not needed. RN-C stated a pressure reducing mattress would arrive within 12 hours when requested. RN-C stated any member of the nursing staff were able to order a pressure reducing mattress. At 11:39 a.m. RN-C verified R1's care plan identified a pressure relieving mattress but was unsure why. RN-C stated ordering the air mattress was "likely missed." At 12:08 p.m. RN-C verified the medical supplier never received a request for a pressure reliving mattress for R1.

In an interview on 7/20/21, the director of nursing

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2 905	Continued From page 6 (DON) stated staff were expected to follow a resident's care plan and nursing assistant task sheet. The DON stated an order for a pressure relieving mattress should be placed within 24 hours. A facility policy titled Skin Integrity Management modified 6/2021, directed to implement preventative measures and to provide appropriate treatment for residents whose conditions increase their risk for skin injury. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to repositioning. The DON, or designee, could train staff and conduct audits to ensure care plans are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		