

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

January 20, 2022

Administrator MBW Company 1407 10th Street North New Ulm, MN 56073

RE: Event ID: EKDC11

Dear Administrator:

On January 14, 2022, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective January 14, 2022.

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correctionk will be completed.

MBW Company January 20, 2022 Page 2

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, MSW, LGSW
Regional Operation Supervisor | Health Regulation Division
Licensing and Certification Program
Office: Golden Rule | St. Paul
PO Box 64900
St. Paul, MN 55164-0900
Minnesota Department of Health
Office/Mobile: (651) 238-8786

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Feel free to contact me with any questions related to this letter.

Sincerely,

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Telephone: 651-201-4121

Enclosure

cc: Licensing and Certification File

PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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		24G457	B. WING _		01/	14/2022
MBW CC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH NEW ULM, MN 56073		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 000		rS /22, an abbreviated survey our facility to conduct a	W 0	00		
	complaint investiga compliance with 42 requirements for In	tion. Your facility was not in CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.				
		plaint was found to be with a deficiency cited at 9896)				
	An Immediate Jeop W331 on 1/11/22, a	pardy (IJ) was identified at at 2:45 p.m.				
	The IJ began on 12/30/21, at 4:00 p.m. when C1 had a sudden decline in condition. Direct support professional (DSP)-A notified the facility licensed practical nurse (LPN) at 4:15 p.m., who directed DSP-A to continue to monitor C1's condition and did not direct DSP what to monitor or to call the physician. C1's condition continued to decline and symptoms worsened. C1 was admitted to the hospital on 12/31/21, and died on 1/1/22, with diagnoses that included aspiration pneumonia, septic shock and hypoxic respiratory failure. The community services director (CSD) was informed of the IJ on 1/11/22, at 2:45 p.m. and the IJ was removed on 1/14/22, at 10:30 a.m., when the facility's approved removal plan was verified onsite by the state agency (SA).					
W 331	onsite revisit of you		W 3:	31		

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

TITLE (X6) DATE

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.

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
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W 331	services in accorda This STANDARD is Based on interview facility failed to com report to the physic of 1 client (C1) who oxygen saturation, and continued vom caused a delay in or resulted in an imme The IJ began on 12 had a sudden declin no indication C1 was communication with condition continued worsened. C1 was died on 1/1/22. The (CSD) was informe p.m. and the IJ was a.m., when the facil was verified onsite Findings include: Review of a facility (submitted to the S had a decline in cor indicated C1 was tr 12/31/21, with a dia pneumonia complic failure (not enough septic shock (life-th and hyponatremia (_	W 33	1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		24G457	B. WING		01	C / 14/2022	
	NAME OF PROVIDER OR SUPPLIER MBW COMPANY			STREET ADDRESS, CITY, STATE, ZIP (1407 10TH STREET NORTH NEW ULM, MN 56073			
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W 331	C1 was admitted to diagnosis listed on record dated 1/3/22 intellectual disability intellectual function in adaptive function movement disability failure and are una dysphagia (condition produce and under Review of the internassessment (ISSA) assessment (SMA) did not have the about medical needs. The was a risk for chok The assessment in were met through a with staff support. It bed at 30 degrees bolsters to assist Coslow bolus syringe excess movement coughing and signs assessment indicate unable to describe The assessment dihealth problems in notes, contact the fand seek medical asymptoms indicate deemed life threated. Review of the care C1 as being depennutritional feedings	the facility in 1990. C1's the face sheet in the medical 2, included; profound y (sub average general ing and significant limitations ning), epilepsy (motor and y), kidney failure (kidneys ble to filler waste), and on that affects the ability to stand spoken language). Issive support services and self management added 10/6/21, indicated C1 ing and aspiration pneumonia. In dicated C1's nutritional needs a gastrostomy tube (g-tube) interventions included; elevate during feeding in bed, utilize in an upright position, utilize nutritional feedings, avoid during feeding and observe for sof regurgitation/ reflux. The ted C1 did not speak and was any symptoms she may have. I rected staff to document any the health T-log progress facility registered nurse (RN) attention for illness or injury as and Call 911 for any situation	W 33				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
	24G457				01/14/2022		
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W 331	Received 250 ml 2 11:00 a.m.) and 12 8:00 p.m.). Interver nutritional feedings monitor tolerance, degrees with feedir times, bolsters to a excessive moveme after feedings, contand signs of regurg closely for aspirationurse and/or physic needed. Review of the physic included orders for 250 ml 2 times dail times daily. Elevate all feedings. Review of the DSF 12/31/21 included; -Entry on 12/29/21,	times daily (at 5:00 a.m. and 5 ml 2 times daily (at 4:00 p.m. at 10:00 bolds with syringe and head of bed (HOB) at 40 mgs and 30 degrees all other id in positioning, avoid ent during feedings for 1 hour tinue to monitor for coughing gitation/reflux and monitor on. Notify the facility license cian as needed and call 911 if icians orders dated 7/29/20, fibersource high nitrogen (HN) y and fibersource HN 125 ml 2 e HOB 45 degrees or higher for 2 T-Log notes from 12/29/21-at 10:24 p.m. by DSP-A ssisted with cares during the	W 33				
	movement. No cha-Entry on 12/30/21, indicated C1 had a 4:00 p.m. C1 was a supplement per g-t feeding, C1 started supplement. Vital s temperature (T) of minutes (BPM) (no oxygen saturation then 90%). C1 had her arms curled un was notified at this	ad a medium soft bowel nges in condition. at 5:12 p.m. by DSP-A, large loose incontinent stool at administered a nutritional ube. After the nutritional to vomit most of her igns (VS) included a 98.4, pulse (P) 50 beats per rmal range 60-100 BPM) and 70% (normal range is greater not opened her eyes and had der her chin. The facility LPN time (4:15 p.m). The LPN monitor C1's condition					

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W 331	to what DSP-A was -Entry on 12/30/21 indicated at 6:30 p not repositioned at vomiting. At 7:30 p amount of mucous At 8:00 p.m. C1 resupplemental feed medium incontiner 8:30 p.m. C1's tem-Entry on 12/31/21 12/30/21, from 9:4 indicated C1 was rutritional feeding the nutritional feeding the nutritional feed began to spit up a Staff repositioned C1 was spitting up soiled the sheets of was bathed at this -Entry on 12/31/21 indicated C1 had a small incontinent unot awaken when unot a	age 4 In no direction from the LPN as a supposed to monitor. I, at 10:19 p.m. by DSP-A, Im. C1 was sleeping. C1 was this time, to prevent further Im. C1 vomited a small and about 1 cup of clear fluid. Decived her nutritional ing per g-tube. C1 had another at loose stool at this time. At aperature was 98.4. If at 2:38 p.m. (late entry for 5 a.m. to 2:00 p.m.) by DSP-D at the tobe wheezing. C1's was given at 11:45 a.m. After ing was administered, C1 small amount of supplement. C1 more up right. At 1:10 p.m. a large amount of phlegm, that in the bed and her clothing. C1 time due to being soiled. If at 6:17 a.m. by DSP-C, quiet night. C1 only had a rine (unusual for client). C1 did repositioned during the night, legs were limp. At 5:15 a.m. C1 brought up a small amount of 1 remained with her eyes in during this time. Staff chose hal feeding at 5:00 a.m. due to 10 a.m. C1 was administered a lient feeding with no emesis at 12:40 p.m. by DSP-B, Im. C1 was resting in bed. C1 this time, and noted her arms at 12:40 p.m. by DSP-B, Im. C1 slept while providing and to have a "gurgling" sound in the total and the control of the	W 3	31			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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W 331	administering the ristarted to vomit more contacted the facility was directed to call ambulance arrived hospital. When trastretcher, C1 did not respirations (R) or -12/29/21, at 4:47 saturation 94% (not respirations (R) or -12/30/21, at 4:50 saturation 70% (not -12/31/21-at 8:00 a saturation 86%, There were no oth medical record from C1 exhibited signs condition, that inclusaturation. Review saturation log averaturation log averaturation log averaturation log averaturation and pulse between Review of a emergreport dated 12/31 EMS was dispatch on 12/31/21. The riethargic and not re R18 and oxygen saturation after administration after administration	ritional supplement. Right after nutritional supplement, C1 ost of her supplement. DSP-B ity LPN, at 11:15 a.m. DSP-B il 911. At 11:45 a.m. the and C1 was transported to the nsferring C1 on to the ot move or open her eyes. ; p.mP 77 BPM, oxygen o blood pressure (B/P), temperature taken). p.mP 50 BPM, oxygen o B/P, R or temperature taken) a.m P 80 BPM, oxygen 97.6 (no B/P taken) er VS documented in C1's m 12/30/21 to 12/31/21, when and symptoms of a decline in uded a low pulse and oxygen of C1's pulse and oxygen of C1's pulse and oxygen ages (for the past 2 months, je in condition), indicated C1's levels were between 90-99% in 70-84 BPM (normal ranges). gency medical service (EMS) //21, at 1:41 p.m. indicated ed to the facility at 11:34 a.m. eport indicated C1 was esponsive. B/P 125/62, P 80, aturation below 80%. Oxygen at 10 liters per EMT. C1's improved gradually to 90%	W3	331		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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W 331	was brought to the on 12/31/21, at 11: lethargy, limp extre and low pulse. C1 further treatment. I developed hypoten hypoxic respiratory transferred to the infurther treatment. Cantibiotics, fluids at C1 expired on 1/1/2 she provided cares a.m. to 2:30 p.m. Interview on 1/10/2 s	/31/21 to 1/1/22, indicated C1 emergency department (ED) 59 a.m. with symptoms of emities, low oxygen saturation was admitted to the hospital for During the hospital stay, C1 ision and showed signs of a distress. C1 was then intensive care unit (ICU) for C1 received treatment of and oxygen while in the hospital. 22 at 8:09 a.m. 22, at 1:50 p.m. DSP-B stated is for C1 on 12/31/21, from 6:00 DSP-B indicated when starting leeping. DSP-B stated C1 was and her limbs were limp when so was noted to have est. At 8:00 a.m. C1's period oxygen ent. C1 was given her intensive call feeding (per g-tube) at 11:00 ely started to vomit a largement. DSP-B indicated she LPN at 11:10 a.m. due to C1's inge in condition. The facility P-B to call the ambulance to ED to be evaluated.					
	notified the facility symptoms and chat LPN instructed DS transport C1 to the Interview on 1/10/2 when arrived to wo C1 was sleeping. A vomiting a large an after a nutritional fed DSP-A indicated C stool, had her eyes	LPN at 11:10 a.m. due to C1's inge in condition. The facility P-B to call the ambulance to ED to be evaluated. 22, at 2:00 p.m. DSP-A stated ork on 12/30/21, at 2:30 p.m.					

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W 331	temperature was saturation was 70 notified the facility instructed her to condition. DSP-A recheck C1's puls saturations. Interview on 1/11/ she provided care a.m. to 2:30 p.m. anything unusual morning. DSP-D a nutritional suppl tolerated it well. Dp.m., C1 started to phlegm and was a DSP-D verified not thought C1 may have thought C1 may have care a provider 12/30/21, at 4:15 notified. C1 should be conditioned to the condition	normal, P 50 BPM and oxygen %. DSP-A indicated she LPN at around 4:30 p.m. who continue to monitor C1's further indicated she failed to be and check her oxygen 22, at 10:30 a.m. DSP-D stated for C1 on 12/30/21, from 9:45 DSP-D stated she did not notice with C1's health status, that indicated C1 was administered ement at 11:00 a.m. and DSP-D indicated around 2:00 or cough and spit up a lot of noted to have a slight wheeze.	W	331			
	licensed and unlice reporting a change facility RN further	censed staff had been trained on e in a clients condition. The indicated all staff were trained icensed nurse, if there was a					
	she worked the ni provided cares fo evening staff repo not feeling well. D	22, at 1:15 p.m. DSP-C stated ight shift on 12/30/21, and r C1. DSP-C indicated the orted C1 had been vomiting and dSP-C stated the evening staff facility LPN had been notified of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		24G457	B. WING		01/14/202	22	
MBW CC	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH NEW ULM, MN 56073			
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W 331	had not been inform saturation and pulsinght, C1 was incoro of urine, of which walso indicated C1 brepositioning her in usually resist and k DSP-C also indicated a labored. DSP-C ad supplement (per-gregurgitated some confirmed she had Interview on 1/11/2 confirmed she had C1's change in conp.m. The facility LP had vomited a large supplement feeding of 70% and a low pfacility LPN indicates specific instructions C1, other than to condition. The facility LPN indicates been notified of C1 The facility LPN indicates been notified of C1 The facility LPN also document in C1's in been notified of C1 review what had occurred in the province of the province had not been award during a condition of indicated C1 should indicate C1 should indicated C1 should indicated C1 should indicate C1 should indicated C1 should indicated C1 should indicated C1 should indicate C1 should indicate C1 should indicated C1 should indicated C1 should indicated C1 should indicated C1 should indicate C1 s	15 p.m. DSP-C indicated she ned of C1's low oxygen e. DSP-C indicated during the ntinent of only a small amount was unusual for her. DSP-C recame limp when bed. DSP-C stated C1 will ick out, but did not move. ed C1's breathing was slightly ministered C1's nutritional tube) at around 5:30 a.m., C1 of the supplement. DSP-C not obtained C1's VS's. 2, at 1:30 p.m. the facility LPN been notified by DSP-A of dition on 12/30/21, at 4:15 N stated she was informed C1 amount (after a nutritional g), had a low oxygen saturation rulse rate of 50 BPM. The ed she did not give DSP-A any son what to do or monitor for ontinue to monitor her ity LPN verified the symptoms a change in her condition. The ed a provider should have 's decline for further treatment. To confirmed she had failed to nedical record that she had 's change in condition, or	W 331				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′			(X3) DATE SURVEY COMPLETED C		
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE		
when C1 exhibited Attempted to conta 1/12/21, at 1:00 p.n. Review of the facility Tasks dated 5/24/2 is below 90% have deep breaths and of to be below 90% conurse. Radial Pulse below 55 BPM or at the purpose of the land safety of personguidelines, for the condition of the purpose of the land safety of personguidelines, for the conditions of the land safety of personguidelines, for the conditions of the land safety of personguidelines, for the conditions of the land safety of personguidelines, for the conditions of the land safety of personguidelines, for the conditions of the land safety of personguidelines, for the conditions of the land safety of personguidelines, for the conditions of the land safety o	a change in condition. ct C1's hospital provider on m., but unavailable. ty policy Delegated Nursing 1, Pulse Oximeter; if reading the client take a couple of cough. If the reading continues ontact the facility licensed e; notify the nurse if pulse is bove 100 BPM. ty policy Health Service Care dated 9/19/17, indicated policy is to promote the health ans served through establishing coordination and care of health hess; if a person develops of illness that is a change in con, an appointment shall be etimely diagnosis and cointment is not available the day with the persons primary rovider may be seen. If he walk in clinic or ED. Itention; If symptoms are felt to staff will first call 911. All is must be documented in the call of the day with the documented in the call of the documented in the staff will first call 911. All is must be documented in the call of the documented in the call of the documented in the call of the documented in the documented and unlicensed staff. The view and updates of policies						
	ROVIDER OR SUPPLIER MPANY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa when C1 exhibited Attempted to conta 1/12/21, at 1:00 p.r Review of the facili Tasks dated 5/24/2 is below 90% have deep breaths and of to be below 90% conurse. Radial Pulse below 55 BPM or a Review of the facili Coordination and C the purpose of the and safety of perso guidelines, for the or related services. Illi signs or symptoms their health condition scheduled to assur treatment. If an app same or following of provider, another p necessary, utilize the Seeking medical at be life threatening, health Care change health T-logs. The IJ began on 1 removed on 1/14/2 facility RN, for licen training included re and procedures for	ROVIDER OR SUPPLIER MPANY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 when C1 exhibited a change in condition. Attempted to contact C1's hospital provider on 1/12/21, at 1:00 p.m., but unavailable. Review of the facility policy Delegated Nursing Tasks dated 5/24/21, Pulse Oximeter; if reading is below 90% have the client take a couple of deep breaths and cough. If the reading continues to be below 90% contact the facility licensed nurse. Radial Pulse; notify the nurse if pulse is below 55 BPM or above 100 BPM. Review of the facility policy Health Service Coordination and Care dated 9/19/17, indicated the purpose of the policy is to promote the health and safety of persons served through establishing guidelines, for the coordination and care of health related services. Illness; if a person develops signs or symptoms of illness that is a change in their health condition, an appointment shall be scheduled to assure timely diagnosis and treatment. If an appointment is not available the same or following day with the persons primary provider, another provider may be seen. If necessary, utilize the walk in clinic or ED. Seeking medical attention; If symptoms are felt to be life threatening, staff will first call 911. All health care changes must be documented in the	ROVIDER OR SUPPLIER MPANY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 when C1 exhibited a change in condition. Attempted to contact C1's hospital provider on 1/12/21, at 1:00 p.m., but unavailable. Review of the facility policy Delegated Nursing Tasks dated 5/24/21, Pulse Oximeter; if reading is below 90% have the client take a couple of deep breaths and cough. If the reading continues to be below 90% contact the facility licensed nurse. Radial Pulse; notify the nurse if pulse is below 55 BPM or above 100 BPM. Review of the facility policy Health Service Coordination and Care dated 9/19/17, indicated the purpose of the policy is to promote the health and safety of persons served through establishing guidelines, for the coordination and care of health related services. Illness; if a person develops signs or symptoms of illness that is a change in their health condition, an appointment shall be scheduled to assure timely diagnosis and treatment. If an appointment is not available the same or following day with the persons primary provider, another provider may be seen. If necessary, utilize the walk in clinic or ED. Seeking medical attention; If symptoms are felt to be life threatening, staff will first call 911. All health care changes must be documented in the health T-logs. The IJ began on 12/30/21, at 4:00 p.m. and was removed on 1/14/22, at 10:30 a.m. when the facility provided 1:1 training/re-education by the facility provided review and updates of policies and procedures for gastrostomy nutritional	ROVIDER OR SUPPLIER ### A BUILDING 24G457 B. WING STREET ADDRESS, CITY, STATE, ZIP COT 1407 10TH STREET NORTH NEW ULM, MN 56073	ROVIDER OR SUPPLIER ### APANY #		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED		
		24G457	B. WING			C 01/14/2022	
	NAME OF PROVIDER OR SUPPLIER MBW COMPANY			STREET ADDRESS, CITY, STATE, ZIP COD 1407 10TH STREET NORTH NEW ULM, MN 56073		1-112022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 331	saturation, paramet temperature, pulse Education was prov symptoms for a clie to notify the facility and timely documed assurance (QA) con continued complian the CSD, DSP-C ar	ters for VS's that included and respirations (TPR), vided on guidance of signs and ents change in condition, when licensed nurse and/or provider nation. The facility quality mmittee will review and audit ace. Interviews conducted with and facility RN on 1/14/22, 10:30 a.m. confirmed the	W 3	31			

PRINTED: 02/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED	
		24G457		B. WING		I	0
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MBW ON	I TENTH				407 10TH STREET NORTH		
			1/4	EW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000		/22, an abbreviated survey	w o	000	approved 2/25/22 -SG		
	complaint investiga	our facility to conduct a tion. Your facility was not in			Sarah Digitally		y Sarah
		CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities.			Grebenc Grebenc Grebenc Grebenc Grebenc		11:39:06
		laint was found to be with a deficiency cited at 9896)	e e				
	An Immediate Jeop W331 on 1/11/22, a	ardy (IJ) was identified at t 2:45 p.m.					
·	had a sudden declir professional (DSP)-practical nurse (LPI DSP-A to continue did not direct DSP v physician. C1's consymptoms worsene hospital on 12/31/2 diagnoses that incluseptic shock and hy community services of the IJ on 1/11/22 removed on 1/14/22	/30/21, at 4:00 p.m. when C1 ne in condition. Direct support A notified the facility licensed N) at 4:15 p.m., who directed to monitor C1's condition and what to monitor or to call the dition continued to decline and d. C1 was admitted to the 1, and died on 1/1/22, with uded aspiration pneumonia, poxic, respiratory failure. The director (CSD) was informed at 2:45 p.m. and the IJ was 2, at 10:30 a.m., when the emoval plan was verified agency (SA).					
W 224	onsite revisit of you		14/ 0	104			
W 331	MUKSING SEKVIC	EO	W 3	33T			
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITI F		(X6) DATE

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF F	DOVIDED OF AUDDLIED	24G457	B. WING		***************************************	01/14/2022
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	services in accorda This STANDARD is Based on interview facility failed to com report to the physici of 1 client (C1) who oxygen saturation, I and continued vomi caused a delay in caresulted in an imme The IJ began on 12 had a sudden declir no indication C1 wa communication with condition continued worsened. C1 was died on 1/1/22. The (CSD) was informed p.m. and the IJ was a.m., when the facili was verified onsite is Findings include: Review of a facility of (submitted to the SA had a decline in con indicated C1 was tra 12/31/21, with a diag pneumonla complication of the continued septic shock (life-the and hyponatremia (I	ovide clients with nursing nce with their needs. In not met as evidenced by: In and document review, the prehensively assess and an a decline in condition for 1 exhibited symptoms of a low ow pulse, lethargy, wheezing ting and diarrhea. This practice diate jeopardy (IJ) for C1. If a condition and there was a consistently monitored or the physician when C1's to decline and symptoms hospitalized on 12/31/21, and a community services director of the IJ on 1/11/22, at 2:45 removed on 1/14/22, at 10:30 ty's approved removal plan by the state agency (SA).	W	331	W 331 Nursing Services Corrected 1/21/2022 C1 Passed away on 12/31/2021 At the hospital. Reviewed and updated policy POLICY AND PROCEDURE PERTAINING HEALTH SERVICE COORDINATION AND Reviewed and updated training inform Gastrostomy and Aspiration pneumor Retraining of importance of timely convitable on the physician for condition in client physical or mental on the vital signs parameters for whate whate should be reported to the EOT nurse and/or the physician, of when physician should be notified as Emergency services be contacted for the Emergency Room, on importance of dof client change in condition, needs to be documented before leaving on tube feeding procedures and implications or adverse reactions could occur due to tube feedings. Date of retraining Immediate and on a was sent out via S-Comm, in person and with read and Sign. Date of retraining 1/11/2022 done via and specific phone conversations with to each next shift worked. In person we staring on 1/12/2022. EON lnc was als with staff at staff meeting on 1/20/20 did meet with current staff working to Retraining was done with nursing, Direct Support Professionals, Community Service Supervisor, Community Supports Program Directors.	or CARE nation on hia. mmunication change in health status, t is acceptable N Inc. facility and/or cransport to ocumentation ng shift, that going nd S-Comm, e each staff prior vas be done to followed up 22 EON Inc. day 1/11/2022.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		24G457	B. WING		C 04/4/2022
NAME OF	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH NEW ULM, MN 56073	01/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
W 331	C1 was admitted to diagnosis listed on record dated 1/3/22 intellectual disability intellectual function in adaptive function movement disability failure and are unall dysphagia (conditio produce and unders). Review of the intensassessment (ISSA) assessment (SMA) did not have the abimedical needs. The was a risk for choki The assessment in were met through a with staff support. In bed at 30 degrees coolsters to assist Cool	the facility in 1990. C1's the face sheet in the medical ting and significant limitations that affects the face sheet in the face sheet the face sheet the face sheet in the medical the face sheet the face sheet in the medical the face sheet the face sheet in the face sheet the face sh	W	W 331 Nursing Services Corrected 1/21/2022 C1 Passed away on 12/31/ At the hospital. C2 whom resides in the location had Plan of care and medical record revie Nursing, Community Services Director Program Director, Supervisor DSP, all trained to ensure that notifica Nursing and Physicians are notified in The RN and QIDDP will ensure that th Kept up to date and that there will be training in these areas. QIPPD and RN will regularly review me Program file to ensure that Physician a Notification are competed in a timely If found not completed then RN and C Promptly update physician and report Community Services Director. Training documents will be kept by HR each staff HR folder to ensure complia	wed by tions a timely manner ese areas are on going edical and and Nurse manner. IPPD will incident to

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		24G457	B. WING			C 04/44/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=	01/14/2022
MBW O	N TENTH			1407 10TH STREET NORTH NEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD	BE COMPLETION
W 331	11:00 a.m.) and 128 8:00 p.m.). Interven nutritional feedings monitor tolerance, I degrees with feeding times, bolsters to ai excessive moveme after feedings, cont and signs of regurg closely for aspirationurse and/or physic needed. Review of the physic included orders for 250 ml 2 times daily times daily. Elevate all feedings. Review of the DSP 12/31/21 included; -Entry on 12/29/21, indicated C1 was as evening shift and hamovement. No charentry on 12/30/21, indicated C1 had a 4:00 p.m. C1 was a supplement per g-tofeeding, C1 started supplement. Vital sitemperature (T) of siminutes (BPM) (nor oxygen saturation 7 then 90%). C1 had her arms curled undwas notified at this fill.	times daily (at 5:00 a.m. and 5 ml 2 times daily (at 4:00 p.m. ations included; give g-tube at slow bolus with syringe and nead of bed (HOB) at 40 ags and 30 degrees all other id in positioning, avoid nt during feedings for 1 hour inue to monitor for coughing itation/reflux and monitor n. Notify the facility license cian as needed and call 911 if cians orders dated 7/29/20, fibersource high nitrogen (HN) and fibersource HN 125 ml 2 HOB 45 degrees or higher for T-Log notes from 12/29/21-at 10:24 p.m. by DSP-A sesisted with cares during the and a medium soft bowel	W 3	331		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		24G457	B. WING_		C 01/14/2022
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W 331	to what DSP-A was -Entry on 12/30/21 indicated at 6:30 p. not repositioned at vomiting. At 7:30 p. amount of mucous At 8:00 p.m. C1 rec supplemental feedi medium incontinent 8:30 p.m. C1's tempentary on 12/31/21, 12/30/21, from 9:45 indicated C1 was non utritional feeding with enutritional feeding was bathed at this tentry on 12/31/21, indicated C1 had a small incontinent ur not awaken when reand her arms and lebegan to retch and phlegm and bile. Colosed and letharging to hold the nutrition the retching. At 5:50 nutritional supplementation of the propositional supplementation of the positional supplementation of the position of the	no direction from the LPN as supposed to monitor. , at 10:19 p.m. by DSP-A, m. C1 was sleeping. C1 was this time, to prevent further m. C1 vomited a small and about 1 cup of clear fluid. reived her nutritional and per g-tube. C1 had another toose stool at this time. At	W 33	31	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		24G457	B, WING		01	C 1/ 14/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1407 10TH STREET NORTH NEW ULM, MN 56073		I TT de V de Jee
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
W 331	administering the nestarted to vomit mo contacted the facilit was directed to call ambulance arrived hospital. When transtretcher, C1 did not respiration (Review of C1's VS; -12/29/21, at 4:47 psaturation 94% (no respirations (R) or t-12/30/21, at 4:50 psaturation 70% (no -12/31/21-at 8:00 as attraction 86%, T 9). There were no other medical record from C1 exhibited signs a condition, that inclust attraction. Review of saturation log averaging to C1's change oxygen saturation leand pulse between. Review of a emerger report dated 12/31/2 EMS was dispatched on 12/31/21. The relethargic and not respiration is and oxygen saturation in after administration.	itional supplement. Right after utritional supplement, C1 st of her supplement. DSP-B y LPN, at 11:15 a.m. DSP-B 911. At 11:45 a.m. the and C1 was transported to the sferring C1 on to the it move or open her eyes. I.MP 77 BPM, oxygen blood pressure (B/P), emperature taken). I.MP 50 BPM, oxygen B/P, R or temperature taken) mP 80 BPM, oxygen 7.6 (no B/P taken) I. VS documented in C1's in 12/30/21 to 12/31/21, when and symptoms of a decline in inded a low pulse and oxygen of C1's pulse and oxygen in ges (for the past 2 months, in condition), indicated C1's evels were between 90-99% 70-84 BPM (normal ranges). I. Recomplete the post 2 months, in condition), indicated C1's evels were between 90-99% 70-84 BPM (normal ranges). I. Recomplete the post 2 months, in condition of the past 2 months, in condition), indicated C1's evels were between 90-99% 70-84 BPM (normal ranges). I. Recomplete the post 2 months, in condition of the past 2 months, in condition), indicated C1's evels were between 90-99% 70-84 BPM (normal ranges). I. Recomplete the post 2 months, in condition of the past 2 months, in condition), indicated C1's evels were between 90-99% 70-84 BPM (normal ranges). I. Recomplete the past 2 months, in condition of the past 2 months at 2 months and 2 months at 2	W 3	331		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		24G457	B. WING_		C 01/14/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH NEW ULM, MN 56073	01/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
W 331	was brought to the on 12/31/21, at 11:5 lethargy, limp extreand low pulse. C1 v further treatment. Determined by transferred to the infurther treatment. Cantibiotics, fluids and C1 expired on 1/1/2 she provided cares a.m. to 2:30 p.m. Dher shift, C1 was sleepier than usual repositioned. C1 also wheezing in the chet temperature was 9 saturation 80 percescheduled nutritiona a.m. and immediate amount of supplementified the facility L symptoms and chart LPN instructed DSF transport C1 to the Interview on 1/10/22 when arrived to wor C1 was sleeping. At vomiting a large amafter a nutritional fer DSP-A indicated C1 stool, had her eyes were limp. DSP-A in	31/21 to 1/1/22, indicated C1 emergency department (ED) 59 a.m. with symptoms of mities, low oxygen saturation was admitted to the hospital for buring the hospital stay, C1 sion and showed signs of distress. C1 was then attensive care unit (ICU) for at received treatment of ad oxygen while in the hospital. 12 at 8:09 a.m. 12, at 1:50 p.m. DSP-B stated for C1 on 12/31/21, from 6:00 SP-B indicated when starting seeping. DSP-B stated C1 was and her limbs were limp when so was noted to have est. At 8:00 a.m. C1's 7.6, P 86 BPM and oxygen at feeding (per g-tube) at 11:00 sty started to vomit a large lent. DSP-B indicated she limb. The facility P-B to call the ambulance to	W 33		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24G457	B. WING	ı		C 01/14/2022
	PROVIDER OR SUPPLIER	Mark (4)			STREET ADDRESS, CITY, STATE, ZIP CODE	01/14/2022
MBW ON	I TENTH			ľ	NEW ULM, MN 56073	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W 331	saturation was 70% notified the facility Linstructed her to co condition. DSP-A for recheck C1's pulse saturations. Interview on 1/11/22 she provided care fa.m. to 2:30 p.m. Danything unusual with morning. DSP-D in a nutritional suppler tolerated it well. DSp.m., C1 started to phlegm and was no DSP-D verified no Naturational care of the state of the sta	ormal, P 50 BPM and oxygen a. DSP-A indicated she .PN at around 4:30 p.m. who ntinue to monitor C1's .urther indicated she failed to and check her oxygen 2, at 10:30 a.m. DSP-D stated or C1 on 12/30/21, from 9:45 SP-D stated she did not notice the C1's health status, that dicated C1 was administered ment at 11:00 a.m. and P-D indicated around 2:00 cough and spit up a lot of ted to have a slight wheeze. /S's had been taken, and //e the flu. 2, at 11:45 a.m. the facility RN or been aware of a delay in an 12/30/21. The facility RN in 12/30/21. The facility RN in 12/30/21. The facility RN in 12/30/21 in facility RN indicated all med staff had been trained on in a clients condition. The dicated all staff were trained ensed nurse, if there was a	W	331		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY IPLETED
		24G457	B. WING	_	***************************************	i i	C 14/2022
NAME OF	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 107 10TH STREET NORTH EW ULM, MN 56073		TTILVLL
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 331	C1's condition at 4: had not been inform saturation and pulsinight, C1 was incorrof urine, of which walso indicated C1 brepositioning her in usually resist and k DSP-C also indicated labored. DSP-C adsupplement (pergregurgitated some confirmed she had Interview on 1/11/22 confirmed she had C1's change in conp.m. The facility LP had vomited a large supplement feeding of 70% and a low p facility LPN indicate specific instructions C1, other than to condition. The facility LPN indicate been notified of C1' The facility LPN also document in C1's more been notified of C1' review what had oc Interview on 1/11/22 community service had not been award during a condition cindicated C1 should indicated C1 should indicate C1 sho	15 p.m. DSP-C indicated she ned of C1's low oxygen e. DSP-C indicated during the atinent of only a small amount as unusual for her. DSP-C ecame limp when bed. DSP-C stated C1 will ick out, but did not move. ed C1's breathing was slightly ministered C1's nutritional tube) at around 5:30 a.m., C1 of the supplement. DSP-C not obtained C1's VS's. 2, at 1:30 p.m. the facility LPN been notified by DSP-A of dition on 12/30/21, at 4:15 N stated she was informed C1 amount (after a nutritional she had a low oxygen saturation ulse rate of 50 BPM. The d she did not give DSP-A any on what to do or monitor for ontinue to monitor her ty LPN verified the symptoms a change in her condition. The d a provider should have so decline for further treatment. To confirmed she had failed to nedical record that she had schange in condition, or	W	331			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		SURVEY PLETED
		24G457	B. WING			01/2	C 14/2022
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	14/2022
MBW ON				1	1407 10TH STREET NORTH NEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	Continued From pa	ge 9	w s	331			
	when C1 exhibited	a change in condition.					
	Attempted to contact 1/12/21, at 1:00 p.n	ct C1's hospital provider on n., but unavailable.					
	Tasks dated 5/24/2 is below 90% have deep breaths and c to be below 90% co	ry policy Delegated Nursing 1, Pulse Oximeter; if reading the client take a couple of ough. If the reading continues ontact the facility licensed r; notify the nurse if pulse is bove 100 BPM.					
	Coordination and C the purpose of the p and safety of perso guidelines, for the c related services. Illr signs or symptoms their health condition scheduled to assure treatment. If an app same or following d provider, another processary, utilize the Seeking medical at be life threatening,	by policy Health Service are dated 9/19/17, indicated policy is to promote the health as served through establishing coordination and care of health aress; if a person develops of illness that is a change in an appointment shall be a timely diagnosis and pointment is not available the any with the persons primary rovider may be seen. If the walk in clinic or ED. It tention; If symptoms are felt to staff will first call 911. All is must be documented in the					
	removed on 1/14/22 facility provided 1:1 facility RN, for licen training included reand procedures for feedings (risks/side	2/30/21, at 4:00 p.m. and was 2, at 10:30 a.m. when the training/re-education by the sed and unlicensed staff. The view and updates of policies gastrostomy nutritional effects), signs and symptoms nonia, parameters for oxygen					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 11 11	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		24G457	B. WING		C 01/14/2022
NAME OF	PROVIDER OR SUPPLIER		 Т	STREET ADDRESS, CITY, STATE, ZIP CODE	UII 14/LULL
MBW ON	J TENTH			1407 10TH STREET NORTH	
				NEW ULM, MN 56073	
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W 331	temperature, pulse Education was prov symptoms for a clie to notify the facility and timely documer assurance (QA) cor continued complian the CSD, DSP-C ar	ters for VS's that included and respirations (TPR), vided on guidance of signs and ents change in condition, when licensed nurse and/or provider ntation. The facility quality mmittee will review and audit ince. Interviews conducted with and facility RN on 1/14/22, 10:30 a.m. confirmed the	W 33	31	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered via Email

January 20, 2022

Administrator MBW Company 1407 10th Street North New Ulm, MN 56073

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number EKDC11

Dear Administrator:

The above facility was surveyed on January 10, 2022 through January 14, 2022 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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 of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Supervised Living Facilities.

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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

When all orders are corrected, the first page of the order form should be signed and returned to:

MBW Company

Page 2

Sarah Grebenc, MSW, LGSW Regional Operation Supervisor | Health Regulation Division Licensing and Certification Program Office: Golden Rule | St. Paul

PO Box 64900

St. Paul, MN 55164-0900

Minnesota Department of Health Office/Mobile: (651) 238-8786

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 Sarah Grebenc. A written plan for correction of licensing orders is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Any Johour

Amy Johnson, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Telephone: 651-201-4121

Enclosure

cc: Licensing and Certification File MBW Company

Page 3

PRINTED: 01/20/2022 FORM APPROVED

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		01598	B. WING		01/14/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
MBW CC	OMPANY		1 STREET N 1, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
5 000	144.56 and/or Minn 144.653, this correct pursuant to a surver found that the deficit herein are not corrected shall with a schedule of the Minnesota Depth Determination of which corrected requires requirements of the number and MN Ruindicated below. Where we will be considered that the corrected during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fire violated from the provided that the Department with notice of assessment of a fire violated from the provided that the Department with notice of assessment of a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fire violated during the corrected.	nether a violation has been compliance with all rule provided at the tag alle number or MN Statute then a rule or statute contains to to comply with any of the lered lack of compliance. It is upon re-inspection with any alle will result in the le even if the item that was initial inspection was the aring on any assessments in non-compliance with these is a written request is made to the initial inspection was antifer non-compliance. 22, a complaint investigation our facility was found to be not requirements of Minnesota 5 requirements for Supervised	5 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota state statutes/rules for Supervised Living Facilities. The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state states."	oftware. to s in the ag." the

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
,	0. 00	.52.11.10/11/61/11/61/15211	A. BUILDING:			
		01598	B. WING		01/1	4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MBW CO	DMPANY		STREET N , MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
5 000	Continued From pa When corrections a date, make a copy electronically return Sarah Grebenc sarah.grebenc@sta	are completed, please sign and of these orders and to:	5 000	out of compliance is listed in the "Summary Statement of Deficienc column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION.	ply" his which after the s DING OF THIS ON FOR	
5 380	SERVICES. Health services share optimal general lever function, prevent discrete development of each of the services. This MN Requirement by: Based on interview facility failed to compress to the physic of 1 client (C1) who oxygen saturation, and continued vomes.	D PURPOSE OF HEALTH all be utilized to maintain an el of health and to maximize sability, and promote optimal ch resident. ent is not met as evidenced and document review, the prehensively assess and ian a decline in condition for 1 exhibited symptoms of a low ow pulse, lethargy, wheezing iting and diarrhea. This are/treatment. This practice	5 380	VIOLATIONS OF MINNESOTA ST STATUTES/RULES.	AIE	

Minnesota Department of Health

STATE FORM 6899 EKDC11 If continuation sheet 2 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
01598					01/1	4/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MBW CC	MPANY		I STREET N I, MN 56073			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE
5 380	The IJ began on 12 had a sudden declino indication C1 was communicating with condition continued worsened. C1 was died on 1/1/22. The (CSD) was informe p.m. and the IJ was a.m., when the facil was verified onsite Findings include: Review of a facility (submitted to the S. had a decline in conindicated C1 was tr 12/31/21, with a dia pneumonia complic failure (not enough septic shock (life-thand hyponatremia (expired at the hosp) C1 was admitted to diagnosis listed on record dated 1/3/22 intellectual disability intellectual function in adaptive function movement disability failure and are unal dysphagia (conditio produce and understand in the control of the	ge 2 ediate jeopardy (IJ) for C1. 2/30/21, at 4:00 p.m. when C1 ne in condition and there was as consistently monitored or n the physician when C1's to decline and symptoms hospitalized on 12/31/21, and e community services director d of the IJ on 1/11/22, at 2:45 for removed on 1/14/22, at 10:30 lity's approved removal plan by the state agency (SA). death report dated 12/30/21, A) by the facility indicated C1 ndition on 12/30/21. The report ansferred to the hospital on agnosis of aspiration cated by hypoxic respiratory oxygen in the blood), severe areatening organ dysfunction) flow level of sodium). C1 atal on 1/1/22, at 8:09 a.m. The facility in 1990. C1's the face sheet in the medical c, included; profound by (sub average general ing and significant limitations ing), epilepsy (motor and by), kidney failure (kidneys one to filler waste), and on that affects the ability to stand spoken language). sive support services	5 380			
		and self management				

Minnesota Department of Health

STATE FORM 6899 EKDC11 If continuation sheet 3 of 11

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		01598	B. WING		01/1	2 4/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE		
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MBW CC	JWIPAN Y	NEW ULM	, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
5 380	REGULATORY OR LSC IDENTIFYING INFORMATION)		5 380			
	(ml) daily per dietic Received 250 ml 2 11:00 a.m.) and 125 8:00 p.m.). Interven nutritional feedings monitor tolerance, h degrees with feedin times, bolsters to ai excessive movement after feedings, conti- and signs of regurgiclosely for aspiration	` ,				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOLEBINO.		С	
		01598	B. WING			4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MBW CO	DMPANY		H STREET N I, MN 56073	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
17.0		,		DEFICIENCY)		
5 380	Continued From pa	ge 4	5 380			
	Review of the physicians orders dated 7/29/20, included orders for fibersource high nitrogen (HN) 250 ml 2 times daily and fibersource HN 125 ml 2 times daily. Elevate HOB 45 degrees or higher for all feedings.					
	included orders for fibersource high nitrogen (HN) 250 ml 2 times daily and fibersource HN 125 ml 2 times daily. Elevate HOB 45 degrees or higher for					

Minnesota Department of Health

STATE FORM 6899 EKDC11 If continuation sheet 5 of 11

Minnesc	<u>ita Department of He</u>	ealth				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					_	_
		D WING				
01598		B. WING		01/14/2022		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
INAIVIL OI I	- NOVIDEN ON SUFFEIEN					
MBW CC	MPANY		H STREET N			
		NEW ULN	I, MN 56073			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
5 380	Continued From pa	ge 5	5 380			
0 000	•					
	the nutritional feedi	ng was administered, C1				
	began to spit up a s	small amount of supplement.				
	Staff repositioned C	C1 more up right. At 1:10 p.m.				
	C1 was spitting up	a large amount of phlegm, that				
		n the bed and her clothing. C1				
		ime due to being soiled.				
		at 6:17 a.m. by DSP-C,				
		quiet night. C1 only had a				
		ine (unusual for client). C1 did				
		epositioned during the night,				
		egs were limp. At 5:15 a.m. C1				
		brought up a small amount of				
		1 remained with her eyes				
		c during this time. Staff chose				
		al feeding at 5:00 a.m. due to				
		0 a.m. C1 was administered a				
	• •	ent feeding with no emesis				
	after.					
		at 12:40 p.m. by DSP-B,				
	indicated at 6:00 a.	m. C1 was resting in bed. C1				
	was repositioned at	this time, and noted her arms				
	and legs to be limp	. C1 slept while providing				
	cares. C1 was note	d to have a "gurgling" sound in				
		t 11:00 a.m. Č1 was				
		itional supplement. Right after				
		utritional supplement, C1				
		st of her supplement. DSP-B				
		y LPN, at 11:15 a.m. DSP-B				
		911. At 11:45 a.m. the				
		and C1 was transported to the				
		•				
	hospital. When transferring C1 on to the stretcher, C1 did not move or open her eyes.					
	Suctoner, Or and He	n move or open her eyes.				
	Povious of C415 VC.					
	Review of C1's VS;					
		o.mP 77 BPM, oxygen				
		blood pressure (B/P),				
	respirations (R) or t	• ,				
		.mP 50 BPM, oxygen				
		B/P, R or temperature taken)				
	-12/31/21-at 8:00 a.m P 80 BPM, oxygen					

STATE FORM 6899 If continuation sheet 6 of 11 EKDC11

AND PLAN OF CORRECTION IDENTIFICATION NOWIBER. A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	C	
01598 B. WING 01/14/2	/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MBW COMPANY 1407 10TH STREET NORTH NEW ULM, MN 56073		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
5 380 Continued From page 6 saturation 86%, T 97.6 (no B/P taken) There were no other VS documented in C1's medical record from 12/30/21 to 12/31/21, when C1 exhibited signs and symptoms of a decline in condition, that included a low pulse and oxygen saturation. Review of C1's pulse and oxygen saturation log averages (for the past 2 months, prior to C1's change in condition), indicated C1's oxygen saturation levels were between 90-99% and pulse between 70-84 BPM (normal ranges). Review of a emergency medical service (EMS) report dated 12/31/21, at 1.41 p.m. indicated EMS was dispatched to the facility at 11:34 a.m. on 12/31/21. The report indicated C1 was lethargic and not responsive. B/P 125/62, P 80, R18 and oxygen saturation below 80%. Oxygen was administered at 10 liters per EMT. C1's oxygen saturation improved gradually to 90% after administration. Review of a hospital admission/discharge summary dated 12/31/21 to 11/1/22, indicated C1 was brought to the emergency department (ED) on 12/31/21, at 11:59 a.m. with symptoms of lethargy, limp extremilies, low oxygen saturation and low pulse. C1 was admitted to the hospital for further treatment. During the hospital stay, C1 developed hypotension and showed signs of hypoxic respiratory distress. C1 was then transferred to the intensive care unit (ICU) for further treatment. C1 received treatment of antibiotics, fluids and oxygen while in the hospital. C1 expired on 1/1/22 at 8:09 a.m. Interview on 1/10/22, at 1:50 p.m. DSP-B stated she provided cares for C1 on 12/31/21, from 6:00 a.m. to 2:30 p.m. DSP-B indicated when starting		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		01598	B. WING			C 1 4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MBW C	OMPANY		I STREET NO I, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
5 380	sleepier than usual repositioned. C1 als wheezing in the che temperature was 9 saturation 80 perce scheduled nutritiona a.m. and immediate amount of supplem notified the facility L symptoms and chall LPN instructed DSF transport C1 to the Interview on 1/10/22 when arrived to wor C1 was sleeping. A vomiting a large amafter a nutritional fe DSP-A indicated C1 stool, had her eyes were limp. DSP-A in were unusual for C1 temperature was no saturation was 70% notified the facility L instructed her to co condition. DSP-A fir recheck C1's pulse saturations. Interview on 1/11/22 she provided care for a.m. to 2:30 p.m. D anything unusual will morning. DSP-D in a nutritional suppler tolerated it well. DS p.m., C1 started to	and her limbs were limp when so was noted to have est. At 8:00 a.m. C1's 7.6, P 86 BPM and oxygen nt. C1 was given her al feeding (per g-tube) at 11:00 ely started to vomit a large nent. DSP-B indicated she PN at 11:10 a.m. due to C1's nge in condition. The facility PB to call the ambulance to ED to be evaluated. 2, at 2:00 p.m. DSP-A stated on 12/30/21, at 2:30 p.m. at around 4:00 p.m. C1 started fount of supplement, soon eding was given (per-g tube) also had a large incontinent of closed and her extremities ndicated these symptoms and the extremities of the property of the proper	5 380			

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STATE FORM 6899 EKDC11 If continuation sheet 8 of 11

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH NEW ULM, MN 56073 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME	AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MBW COMPANY STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH NEW ULM, MN 56073 CAN IND SUMMARY STATEMENT OF DEFICIENCIES CROCK CAN IND SECOND							
MBW COMPANY			01598	B. WING		01/1	4/2022
NEW ULM, MN 56073 NEW	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 5 380 Continued From page 8 thought C1 may have the flu. Interview on 1/11/22, at 11:45 a.m. the facility RN indicated she had not been aware of a delay in C1's medical care on 12/30/21. The facility RN stated a provider should have been notified on 12/30/21, at 4:15 p.m. when the facility LPN was notified. C1 should have been assessed and treatment arranged. The facility RN indicated sill licensed and unlicensed staff had been trained on reporting a change in a clients condition. The facility IRN indicated all licensed and unlicensed unuse, if there was a change in a clients condition. Interview on 1/11/22, at 1:15 p.m. DSP-C stated she worked the night shift on 12/30/21, and provided cares for C1. DSP-C indicated the evening staff informed her the facility LPN had been notified of C1's condition at 4:15 p.m. DSP-C indicated she had not been informed of C1's low oxygen saturation and pulse. DSP-C indicated during the night, C1 was incontinent of only a small amount of urine, of which was unusual for her. DSP-C also indicated C1's breathing was slightly labored. DSP-C administered C1's unittional supplement (per-g-tube) at around 5:30 a.m., C1 regurgitated some of the supplement. DSP-C confirmed she had not obtained C1's VS's. Interview on 1/11/22, at 1:30 p.m. the facility LPN	MBW CC	MPANY		_			
thought C1 may have the flu. Interview on 1/11/22, at 11:45 a.m. the facility RN indicated she had not been aware of a delay in C1's medical care on 12/30/21. The facility RN stated a provider should have been notified on 12/30/21, at 4:15 p.m. when the facility LPN was notified. C1 should have been assessed and treatment arranged. The facility RN indicated all licensed and unlicensed staff had been trained on reporting a change in a clients condition. The facility RN further indicated all staff were trained to call the facility licensed nurse, if there was a change in a client's condition. Interview on 1/11/22, at 1:15 p.m. DSP-C stated she worked the night shift on 12/30/21, and provided cares for C1. DSP-C indicated the evening staff reported C1 had been vomiting and not feeling well. DSP-C stated the evening staff informed her the facility LPN had been notified of C1's condition at 4:15 p.m. DSP-C indicated she had not been informed of C1's low oxygen saturation and pulse. DSP-C indicated during the night, C1 was incontinent of only a small amount of urine, of which was unusual for her. DSP-C also indicated C1 became limp when repositioning her in bed. DSP-C stated C1 will usually resist and kick out, but did not move. DSP-C also indicated C1's breathing was slightly labored. DSP-C administered C1's nutritional supplement (per-g-tube) at around 5:30 a.m., C1 regurgitated some of the supplement. DSP-C confirmed she had not obtained C1's VS's.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
labored. DSP-C administered C1's nutritional supplement (per-g-tube) at around 5:30 a.m., C1 regurgitated some of the supplement. DSP-C confirmed she had not obtained C1's VS's. Interview on 1/11/22, at 1:30 p.m. the facility LPN	5 380	thought C1 may have Interview on 1/11/22 indicated she had in C1's medical care of stated a provider sh 12/30/21, at 4:15 p. notified. C1 should treatment arranged licensed and unlice reporting a change facility RN further into call the facility licensed in a client's Interview on 1/11/22 she worked the night provided cares for devening staff report not feeling well. DS informed her the face C1's condition at 4: had not been inform saturation and pulsonight, C1 was incomo furine, of which walso indicated C1 brepositioning her in usually resist and kernet in the state of	ve the flu. 2, at 11:45 a.m. the facility RN ot been aware of a delay in on 12/30/21. The facility RN rould have been notified on m. when the facility LPN was have been assessed and and the facility RN indicated all reset staff had been trained on in a clients condition. The redicated all staff were trained ensed nurse, if there was a condition. 2, at 1:15 p.m. DSP-C stated at shift on 12/30/21, and condition. 2, at 1:15 p.m. DSP-C stated at shift on 12/30/21, and condition. 3, at 1:15 p.m. DSP-C stated at shift on 12/30/21, and condition. 4, at 1:15 p.m. DSP-C stated at shift on 12/30/21, and condition. 5, at 1:15 p.m. DSP-C stated the evening staff condition in the state of the evening staff condition. 6, at 1:15 p.m. DSP-C stated the evening staff condition in the evening staff condition. 7, at 1:15 p.m. DSP-C stated the evening staff condition in the evening staff condition.	5 380			
C1's change in condition on 12/30/21, at 4:15 p.m. The facility LPN stated she was informed C1		labored. DSP-C adr supplement (per-g- regurgitated some of confirmed she had Interview on 1/11/22 confirmed she had C1's change in confirmed	ministered C1's nutritional tube) at around 5:30 a.m., C1 of the supplement. DSP-C not obtained C1's VS's. 2, at 1:30 p.m. the facility LPN been notified by DSP-A of dition on 12/30/21, at 4:15				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		01598	B. WING		01/1	4/2022			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE						
MBW COMPANY 1407 10TH STREET NORTH NEW ULM, MN 56073									
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON.	(YE)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	RECTIVE ACTION SHOULD BE COMPLETE DATE				
5 380	Continued From page 9		5 380						
	supplement feeding), had a low oxygen saturation of 70% and a low pulse rate of 50 BPM. The facility LPN indicated she did not give DSP-A any specific instructions on what to do or monitor for C1, other than to continue to monitor her condition. The facility LPN verified the symptoms C1 exhibited, was a change in her condition. The facility LPN indicated a provider should have been notified of C1's decline for further treatment. The facility LPN also confirmed she had failed to document in C1's medical record that she had been notified of C1's change in condition, or review what had occurred.								
	had not been aware during a condition of indicated C1 should and a provider notif when C1 exhibited	director (CSD) indicated she e of C1's delay in treatment, change. The facility CSD d have been assessed further ied on 12/30/21, at 4:00 p.m. a change in condition.							
	Attempted to contact 1/12/21, at 1:00 p.n	ct C1's hospital provider on n., but unavailable.							
	Tasks dated 5/24/2 is below 90% have deep breaths and c to be below 90% co	ry policy Delegated Nursing 1, Pulse Oximeter; if reading the client take a couple of ough. If the reading continues ontact the facility licensed r; notify the nurse if pulse is bove 100 BPM.							
	Coordination and C the purpose of the p and safety of perso guidelines, for the c related services. Illr	ry policy Health Service are dated 9/19/17, indicated policy is to promote the health as served through establishing coordination and care of health aloness; if a person develops of illness that is a change in							

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STATE FORM 6899 EKDC11 If continuation sheet 10 of 11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE				
MBW COMPANY 1407 10TH STREET NORTH NEW ULM, MN 56073							
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
5 380	their health conditions scheduled to assure treatment. If an approach same or following deprovider, another processary, utilize the Seeking medical at the life threatening, health care change health T-logs. The IJ began on 12 removed on 1/14/22 facility provided 1:1 facility RN, for licentraining included reand procedures for feedings (risks/side of aspiration pneum saturation, parametemperature, pulse Education was proved to notify the facility and timely document assurance (QA) concontinued compliant the CSD, DSP-C arbetween 8:45 and 1 training and educations.	on, an appointment shall be the timely diagnosis and cointment is not available the lay with the persons primary rovider may be seen. If the walk in clinic or ED. Itention; If symptoms are felt to staff will first call 911. All is must be documented in the staff will first call 911. All is must be documented in the training/re-education by the sed and unlicensed staff. The view and updates of policies gastrostomy nutritional in effects), signs and symptoms are for VS's that included and respirations (TPR), wided on guidance of signs and ents change in condition, when the sed nurse and/or provider intation. The facility quality mmittee will review and audit one. Interviews conducted with and facility RN on 1/14/22, 10:30 a.m. confirmed the	5 380				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 01598 01/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH **MBW ON TENTH NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 5 000 **Initial Comments** 5 000 In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. On 1/10/22 to 1/14/22, a complaint investigation Minnesota Department of Health is was conducted. Your facility was found to be not documenting the State Licensing in compliance with requirements of Minnesota Correction Orders using federal software. Rules, Chapter 4665 requirements for Supervised Tag numbers have been assigned to Living Facilities (SLF). Minnesota state statutes/rules for Supervised Living Facilities. The following complaints were found to be SUBSTANTIATED: The assigned tag number appears in the HG457003C (MN79896) with licensing orders far left column entitled "ID Prefix Tag." issued. The state statute/rule number and the corresponding text of the state statute/rule

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

(X6) DATE

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING 01598 01/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH MBW ON TENTH **NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 5 000 5 000 Continued From page 1 When corrections are completed, please sign and out of compliance is listed in the date, make a copy of these orders and "Summary Statement of Deficiencies" electronically return to: column and replaces the "To Comply" portion of the correction order. This Sarah Grebenc sarah.grebenc@state.mn.us column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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. 5 380 MN Rule 4665.3300 PURPOSE OF HEALTH 5 380 SERVICES. 5380 Purpose of Health Services Corrected 1/21/2022 Health services shall be utilized to maintain an Completion date 1/21/2022 optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and report to the physician a decline in condition for 1 of 1 client (C1) who exhibited symptoms of a low oxygen saturation, low pulse, lethargy, wheezing and continued vomiting and diarrhea. This caused a delay in care/treatment. This practice

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 01598 01/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH MBW ON TENTH **NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 5 380 5 380 Continued From page 2 resulted in an immediate jeopardy (IJ) for C1. The IJ began on 12/30/21, at 4:00 p.m. when C1 had a sudden decline in condition and there was no indication C1 was consistently monitored or communicating with the physician when C1's condition continued to decline and symptoms worsened. C1 was hospitalized on 12/31/21, and died on 1/1/22. The community services director (CSD) was informed of the IJ on 1/11/22, at 2:45 p.m. and the IJ was removed on 1/14/22, at 10:30 a.m., when the facility's approved removal plan was verified onsite by the state agency (SA). Findings include: Review of a facility death report dated 12/30/21, (submitted to the SA) by the facility indicated C1 had a decline in condition on 12/30/21. The report indicated C1 was transferred to the hospital on 12/31/21, with a diagnosis of aspiration pneumonia complicated by hypoxic respiratory failure (not enough oxygen in the blood), severe septic shock (life-threatening organ dysfunction) and hyponatremia (low level of sodium). C1 expired at the hospital on 1/1/22, at 8:09 a.m. C1 was admitted to the facility in 1990. C1's diagnosis listed on the face sheet in the medical record dated 1/3/22, included; profound intellectual disability (sub average general intellectual functioning and significant limitations in adaptive functioning), epilepsy (motor and movement disability), kidney failure (kidneys failure and are unable to filler waste).and dysphagia (condition that affects the ability to

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produce and understand spoken language).

Review of the intensive support services assessment (ISSA) and self management

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needed.

nurse and/or physician as needed and call 911 if

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8:30 p.m. C1's temperature was 98.4.

-Entry on 12/31/21, at 2:38 p.m. (late entry for 12/30/21, from 9:45 a.m. to 2:00 p.m.) by DSP-D indicated C1 was noted to be wheezing. C1's nutritional feeding was given at 11:45 a.m. After

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saturation 94% (no blood pressure (B/P), respirations (R) or temperature taken). -12/30/21, at 4:50 p.m.-P 50 BPM, oxygen saturation 70% (no B/P, R or temperature taken) -12/31/21-at 8:00 a.m.- P 80 BPM, oxygen

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C1 expired on 1/1/22 at 8:09 a.m.

Interview on 1/10/22, at 1:50 p.m. DSP-B stated she provided cares for C1 on 12/31/21, from 6:00 a.m. to 2:30 p.m. DSP-B indicated when starting her shift, C1 was sleeping. DSP-B stated C1 was

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a nutritional supplement at 11:00 a.m. and tolerated it well. DSP-D indicated around 2:00 p.m., C1 started to cough and spit up a lot of phleam and was noted to have a slight wheeze. DSP-D verified no VS's had been taken, and

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supplement (per-g-tube) at around 5:30 a.m., C1 regurgitated some of the supplement, DSP-C confirmed she had not obtained C1's VS's.

Interview on 1/11/22, at 1:30 p.m. the facility LPN confirmed she had been notified by DSP-A of C1's change in condition on 12/30/21, at 4:15 p.m. The facility LPN stated she was informed C1 had vomited a large amount (after a nutritional

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 01598 01/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1407 10TH STREET NORTH MBW ON TENTH **NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 5 380 Continued From page 9 5 380 supplement feeding), had a low oxygen saturation of 70% and a low pulse rate of 50 BPM. The facility LPN indicated she did not give DSP-A any specific instructions on what to do or monitor for C1, other than to continue to monitor her condition. The facility LPN verified the symptoms C1 exhibited, was a change in her condition. The facility LPN indicated a provider should have been notified of C1's decline for further treatment. The facility LPN also confirmed she had failed to document in C1's medical record that she had been notified of C1's change in condition, or review what had occurred. Interview on 1/11/21, at 2:00 p.m. with the facility community service director (CSD) indicated she had not been aware of C1's delay in treatment, during a condition change. The facility CSD indicated C1 should have been assessed further and a provider notified on 12/30/21, at 4:00 p.m. when C1 exhibited a change in condition. Attempted to contact C1's hospital provider on 1/12/21, at 1:00 p.m., but unavailable. Review of the facility policy Delegated Nursing Tasks dated 5/24/21, Pulse Oximeter; if reading is below 90% have the client take a couple of deep breaths and cough. If the reading continues to be below 90% contact the facility licensed nurse. Radial Pulse; notify the nurse if pulse is below 55 BPM or above 100 BPM. Review of the facility policy Health Service Coordination and Care dated 9/19/17, indicated the purpose of the policy is to promote the health and safety of persons served through establishing guidelines, for the coordination and care of health

related services. Illness; if a person develops signs or symptoms of illness that is a change in

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