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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NH0D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00419

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245153**
2.STATE VENDOR OR MEDICAID NO.
(L2) **931216100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADONNA TOWERS OF ROCHESTER INC**
(L4) **4001 19TH AVENUE NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/07/2022** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **62** (L18)
13.Total Certified Beds **62** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 02/01/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 02/23/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
____

22. ORIGINAL DATE OF PARTICIPATION
03/14/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
January 19, 2022

Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

RE: CCN: 245153
Cycle Start Date: January 7, 2022

Dear Administrator:

On January 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 3, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 3, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Madonna Towers Of Rochester Inc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 3, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

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

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

(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
E 000	Initial Comments On 1/4/22 through 1/7/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 1/5/22 through 1/7/22 , a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		2/2/22

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

Electronically Signed | 01/26/2022

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F 554	Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete an assessment and education for self-administration of medications for 1 of 1 resident (R3) reviewed for self-administration of medications from a total sample of 16 residents, resulting in the potential for medication errors related to the inappropriate self-administration of medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/15/21, identified cognitively intact and required supervisor for most activities of daily living. R3's diagnoses included, diabetes, rheumatoid arthritis, depression and chronic pain syndrome. During a room observation and interview on 1/4/22, at 10:30 a.m. R3 had multiple prescription medications in her room. R3 verbalized the medications were current medications that she gave them to herself. The medications included eye drops, inhalers, and a topical antifungal cream. R3 stated she performed her own blood sugar checks during the day, approximately four to six times a day, and the supplies were observed in a plastic container on her dresser. R3 stated she informed the nurse when she completed the blood sugar check, and the nurse administered her insulin based on that. R3 further stated, and showed this surveyor, her nebulized mist treatment (NMT) set up in the bottom drawer of her dresser, with four NMT ampules (not labeled) and stated she does her NMT's,	F 554	F 554 R3 self-administration assessment was updated. Orders were reviewed with provider and updated as applicable to include ability to self-check blood glucose levels. Items that were in room were removed or secured if approved for self-administration. Education on use of medications was provided to R3. Residents who are approved for self-administration of medications have the potential to be affected by the alleged practice. Like residents were re-evaluated and orders verified and MAR updated indicating medications that are approved for self-administration. MARS were updated as needed to indicate which medications can be self-administered. The Director of Nursing or designee provided education to licensed nurses, trained medication aides, and certified nursing assistants beginning the week of January 24, 2022 on self-administration of medication, securing medications in resident room or medication cart, and identifying on MAR which medications can be self-administered. The Director of Nursing or designee will complete direct observation audits of self-administration three times weekly for four weeks, twice weekly for four weeks, and then weekly for four weeks. Results of audits will be submitted to the facility Quality Council for Performance	

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F 554	Continued From page 2 "Whenever I feel the need to do them," and that she cleaned the medication cup and mouthpiece on her own when she was done. During an interview on 1/5/22, at 3:45 p.m. and review of the medications in R3's room with R3 present, 16 medications were reviewed with R3. 1. Antihistamine eye drops read one each eye twice a day. R3 stated, "I do myself." 2. Nasal spray one spray each nostril twice a day. R3 stated, "I do myself." 3. Flonase nasal spray two sprays each nostril daily. R3 stated, "I do myself." 4. Ciprodex ear drops two drops right ear for seven days for right ear infection prescribed 6/7/21. R3 stated "I am not using that any longer. I just haven't given it back to the nurse." 5. Two Ventolin (respiratory medication) inhalers (INH) two puffs twice a day. R3 stated "I use the one that shoots out better." However she was unable to state what INH was the preferred one. 6. Diclofenac (mild analgesic) topical cream for mild arthritic pain, use as needed. 7. Lidocaine gel three times a day as needed for moderate/severe arthritis. R3 stated she used the gel for pain if the Diclofenac cream did not work. 8. Two tubes of Triamcinolone Acetonide (antifungal cream) 0.025% cream for, "a rash I had a while ago," medication was prescribed 11/5/21 and resident stated, "I no longer use." 9. Artificial Tears one drop each eye three times as needed prescribed 7/6/21 and resident stated, "I no longer use." 10. Glucose tabs eight tabs in a container of 10 total, resident stated, "it's been a while since I used any as I have others in my purse." 11. DuoNebs (combination respiratory medication of Atrovent and Albuterol) ampules four,	F 554	Improvement for review and recommendations.	

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F 554	Continued From page 3	F 554		

unlabeled in bottom dresser drawer. R3 stated, "it's been a while since I've had to use my breathing machine," and when asked if R3 knew what medication they were, she stated, "no I don't know what it is." R3 also stated the nurse knew she used it when, "they see the machine on my nightstand." R3 further stated the facility had not provided any education to her regarding how to utilize the DuoNeb's, give her eye drops or observe her when doing her own blood sugar checks.

R3's EMR for the January 2022 physician orders, under the, Orders tab revealed orders dated 11/5/21, which included, "resident is ok to self-administer Albuterol, Advair, DuoNebs (all respiratory medications) and Flonase (nasal spray) after set-up." No other specific orders were noted for R3 to complete her blood sugar checks, eye and ear drops or creams.

R3's EMR under the Miscellaneous tab revealed a Self-Administration of Medications assessment, completed on 11/4/21, when R3 was readmitted after a hospitalization. The assessment from 11/4/21, covered her respiratory and nasal medications only, and did not include the eye drops, creams, or completing her own blood sugar checks.

During an interview on 1/6/22, at 10:40 a.m. Registered Nurse (RN)-B stated, the first step to determine if a resident can complete the medication pass they are requesting was to complete a Self-Administration skills observation form. RN-B stated she was aware that R3 kept creams, eye drops, and inhalers in her room, but had not personally gone over them with the resident to see what medications were current

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F 554	Continued From page 4	F 554		

and/or expired. RN-B stated, she typically asked R3 if she had completed the medications for documentation purposes. RN-B stated she was unaware how often the medications were reviewed/looked at for current doses/not expired and stated she did not routinely observe the resident perform her blood sugar checks, complete her eye drops, or inhaler.

During an interview on 1/6/22, at 11:30 a.m. RN-A stated that she completed the Self-Administration of Medications assessment, dated 11/4/21, based on the history of R3 and as part of the re-admission process. RN-A was only able to speak to the respiratory and nasal medications and not the creams, eye drops, or ear drops. RN-A did state that R3 was able to self-administer the respiratory and nasal medications, "after set up by the nurse or trained medication aide [TMA]." RN-A also stated, "after set up" meant the nurse or TMA brought the resident her medication and then resident was allowed to do on her own, but not for the medications to be left in her room.

During an interview on 1/6/22, at 1:30 p.m. with the director of nursing (DON) and licensed practical nurse (LPN)-D, the DON confirmed R3 was able to self-administer her respiratory and nasal medications after set-up by the nurse or TMA, but not to have the medications left in the room. The DON also stated he was not aware until, 1/6/22, that R3 had sixteen medications in her room. The DON stated the facility currently did not have a system in place for review of appropriateness for a resident to continue with self-administration of medications or checking the medications in their room.

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F 554	Continued From page 5 During an interview on 1/6/22 at 4:00 p.m. with R3's medical doctor (MD), she stated she was aware, and agreed, with R3 self-administrating her respiratory and nasal medications. The MD also stated she would expect the facility to notify her if there was any significant change in R3's condition that would that affect R3's ability to continue to self-administer medications. The MD further stated, regarding medications, she would expect the facility would conduct a review of any medications in R3's room to assure that medications are current, not expired or duplicates. The MD further stated the resident may complete her own blood sugar checks, and R3 had conducted a fingerstick for her in December 2021, in which the MD was able to determine her continued ability to do so. The MD stated she was aware R3 had an order for completing her own blood sugar checks but was not aware in the facility EMR that the order, originally dated 6/30/20, had not been reinstated when the resident was re-admitted in December 2021. The MD stated in her EMR system the order showed as active and stated it was an oversight of the facility to not reinstate the order as she continues to feel R3 was capable to complete her own finger sticks. Review of the facility's policy titled, "Self-Administration of Medications," initiated on February 2019 revealed, " ...Residents will approach nurse at the time they are required, and the nurse will transfer the unopened medication to the resident to self-administer ..." and " ...Reevaluation of the ability to self-administer will be done according to the interdisciplinary team (IDT) Observation Guide ..."	F 554		
F 565 SS=E	Resident/Family Group and Response	F 565		2/2/22

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F 565	Continued From page 6 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident Council interview, policy	F 565	F 565	

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F 565	Continued From page 7 review, and review of the Resident Council meeting minutes, it was determined the facility failed to follow up on concerns brought forth by the Resident Council, for five residents (R 3, R11, R15, R17, and R30) who regularly attended council meetings out of a total census of 54. The failure created the potential that residents would not have care needs met or experience weight loss when the facility did not respond to concerns with nursing staffing levels and meal service. Findings include: Review of the facility's undated Resident Council policy revealed, "the facility listens to . . . and acts upon the concerns . . . of the residents . . . The facility demonstrates follow-through on written requests/concerns voiced by the Resident Council." During an interview with the Resident Council on 1/6/22, at 1:11 p.m., all five residents in attendance (R3, R11, R15, R17, and R30) stated that they regularly attended Resident Council in the facility and had been complaining, "for months," about delayed call light response times and lack of staffing. The residents complained that the facility relied heavily on staff from nursing staffing agencies; but the agency staff did not seem to know the resident's specific care needs. All five residents further complained that the facility did not always honor their food preferences and requests or would tell residents they were out of requested food items. The residents reported these concerns were noted in the Resident Council minutes each month, but they did not receive information as to how the facility planned to address the concerns and their concerns had not been resolved.	F 565	R 3, 11, 15, 17, and 30 were visited with and formal concern/grievance process completed for the concerns they have identified with follow up by assigned department for concerns. Residents who have concerns or grievances have the potential to be impacted by the alleged practice. The Social worker was educated on using the concerns and grievance process following Resident Council meetings to ensure follow up is completed. The Regional Nurse Specialist provided education to the Social Worker, Director of Nursing, and Executive Director on using the grievance/concern process to record concerns or grievances and track and document follow up on resident council concerns. The Executive Director or designee will complete follow up audits with identified residents weekly on response to concerns and their satisfaction with- progress towards resolution of concerns. Audits will continue until concerns are resolved to the resident□s satisfaction. Results of audits will be forwarded to the facility Quality Council for Performance Improvement for review and recommendations.	

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F 565	Continued From page 8 Review of the Resident Council Meeting minutes for 7/6/21, 8/3/21, 9/7/21, 10/5/21, 11/2/21, 12/7/21, and 1/4/22, provided by the facility, revealed the Resident Council voiced concerns with food service at each meeting except the meeting on 10/5/21; and concerns with staffing levels all months except 8/3/21. Further review of the Resident Council Meeting minutes revealed no feedback to the residents as to how the facility planned to resolve the concerns, or resident satisfaction with the outcomes. When interviewed on 1/7/22, at 10:31 a.m. the administrator stated, it was his expectation that when the Resident Council brought forth a concern, the Social Worker (SW) would bring it to the attention of the facility leadership team, the leadership team would come up with an action plan to address the concerns, and the SW would keep the residents informed of the progress towards resolution. The administrator stated, he was aware of the residents' concerns, and that the SW would have documentation of the facility's feedback to the residents. "I know we have a communication problem with the residents, and we need to do a better job with that." When interviewed on 1/7/22, at 11:18 a.m. the SW stated, she aware of the ongoing concerns of the Resident Council but had not documented the plans to resolve those concerns or communicated them with the residents. When informed that the residents in attendance felt the facility was not resolving their concerns, the SW stated, "Well that's a lie, but whatever."	F 565		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		2/2/22

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F 657	Continued From page 9 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the care plan for 1 of 3 residents (R30) to reflect resident care needs. Findings include: R30's quarterly Minimum Data Set (MDS) dated 11/17/21 indicated he was cognitively intact, but required partial assistance of one person with his	F 657	F 657 R30 care plan was updated on 01-06-2022 and 01-07-2022. Full care plan review for R30 was completed the week of January 24,2022. Residents who have changes in condition and resultant changes in care plan interventions have the potential to be impacted by the alleged practice. Care	

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F 657	Continued From page 10 oral hygiene. MDS indicated he had an indwelling urinary catheter and an ostomy for bowel function. His diagnosis list included a status of degenerative neurological condition. R30's Oral Health Screening Form from a dental provider indicated that R30 had been examined by them on 9/8/21, and was noted to have upper partial dentures with heavy debris, and only one natural tooth. R30 did not have lower dentures. His oral/dental status was marked as having inflamed [underlined] or bleeding [underlined] gums. The listed daily oral care plan was marked as, "resident needs staff supervision." The recommendations by the dental care provider were, "toothbrushing each morning and evening, brush teeth and gums for approximately 2 minutes, as tolerated, using a soft toothbrush and fluoride toothpaste. Remove partials before brushing teeth. Once daily use a toothbrush or denture brush and mild soap to brush dentures and partials--soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Dry mouth care, use an OTC [over the counter] dry mouth product as needed." The document indicated the notes to nursing staff for follow up/care conference: resident needs partial adjusted. Remind him to take out partial nightly, brush and soak it and brush teeth twice daily. Recommend cleaning and exam." When interviewed on 1/4/22, at 2:51 p.m. R30's family member (FM)-A stated, R30 had a history of periodontal disease, having had to have had an, "expensive gum flap procedure," in the past due to poor oral condition. FM-A said it was important that the facility address R30's dental needs as it was important to avoid further costs	F 657	plan reviews were initiated by the interdisciplinary team the week of January 10, 2022. The use of the printed care guide has been eliminated as the information in the document is available in the electronic health record and accessible by facility and agency staff by reviewing the care plan document. Instructions for viewing care plans was added to the agency orientation guide. Unit managers will review new orders and changes in condition and update care plans on an ongoing basis. The Director of Nursing or designee provided education the week of January 24, 2022 to nursing team members including licensed nurses, trained medication assistants, and certified nursing assistants on care plan updates and accessing care plan and task updates in the electronic health record. The Director of Nursing or designee will audit care plans for updates three times weekly for four weeks, twice weekly for four weeks and then weekly for four weeks. The Director of Nursing or designee will ensure audit includes validating staff understand process to review care plan in the electronic health record. Results of audits will be submitted to the Quality Council for Performance Improvement for review and recommendations.	

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F 657	Continued From page 11	F 657		

and ensure he had adequate oral care.

On 1/6/22, an EHR care plan problem indicating R30 had a colostomy was first added to his care plan since his admission in 2020. A problem area related to R30's need to have a urinary catheter was also added on 1/6/22. A problem related to self-care deficits including in oral cares, was added to the care plan on 10/22/20, but an intervention to remind him to take out his partial dentures nightly, brush and soak it, and brush teeth twice daily was added on 1/7/22, and no other intervention was noted prior to that date. These items were added to the care plan after staff were questioned about the lack of staff direction in these areas.

When interviewed on 1/06/22, at 9:03 a.m. nursing assistant (NA)-A stated, the way she knew to take care of R30 was because he could tell her. She stated he would refuse assistance with brushing, but she would remind him if he had not brushed for long enough. NA-A was not aware of R30's dental concerns and importance of oral care.

On 1/07/22, 8:46 a.m. LPN-C reviewed the EHR care plan and the 1/6/22 paper care guide for R30 and confirmed there were no listed interventions related to his dental problems. LPN-C stated interventions should have been added to the care plan after he was seen for dental care and it was noted he had debris in his mouth, and inflamed tissue. LPN-C confirmed the paper care guide for R30 gave conflicting information when it indicated he was incontinent of bladder and toileting should be offered every 3 hours, but then indicated he had a colostomy bag and urinary catheter.

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F 657	Continued From page 12 When interviewed on 1/7/22, at 9:42 a.m. the director of nursing (DON) stated, clinical managers or floor nurses could update a care plan. The nursing assistant care guide should also be updated. A facility policy titled Comprehensive Assessments and Care Planning not dated but with a copyright of 2017 was provided. The policy outlined the process of completing assessments and updating care plan using the guidelines for the standard MDS upon admission, readmission, quarterly or when there is a significant change. The policy indicated the Care Area Assessments (CAA) would be used to develop the comprehensive care plan, saying: "the facility will use the findings from the CAA process as a starting point for developing the resident's comprehensive plan of care. Note: the facility is responsible for addressing the needs and strength of the resident weather [sic] or not it is included in the CAA process." The policy did not provide information on how to maintain accuracy when changes occur between assessment periods, or how to maintain continuity between the EHR and the handwritten care guides.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		2/2/22

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F 684	Continued From page 13 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff monitored edema and reported indicators of increased edema to the physician for 2 of 3 residents (R108 and R114) reviewed for edema. R108 experienced actual harmed when the facility failed to monitor his edema, failed to notify the physician of a six-pound weight gain in two days, applied compression stockings without a physician's order, and R108 developed two open wounds to his right lower extremity with related pain. Findings include: R108's Face Sheet identified he was admitted to the facility on 12/28/21 with diagnoses including, mild chronic kidney disease, sepsis due to streptococcus, edema, and congestive heart failure (CHF). R108's Observation Detail List Report dated 12/28/21, indicated he had no open areas on his skin at the time of his admission to the facility, and had, "2 + pitting edema" (a build-up of excess fluid in the body to the point an indentation remains for up to 15 seconds after pressure is applied) to his lower extremities. R108's electronic medical record (EMR) revealed he had not had a Minimum Data Set (MDS) assessment completed at the time of survey. R108's Order History included, an order for daily weights for three days after admission beginning 12/29/21, and an order for daily weights	F 684	F684 R108 was assessed and treated for edema and wound care by the medical provider and orders and care plan updated the week of January 5, 2022. Orders have been updated to include edema checks and daily weights with reporting parameters included. R114 has been discharged to home from the facility. Residents with diagnoses of CHF or edema have the potential to be impacted by the alleged practice. Residents with these diagnoses were reviewed by the interdisciplinary team beginning the week of January 10, 2022 and orders were revised and care plans updated if indicated. Review of CHF protocol was completed with medical provider□s nurse liaison, who explained this protocol is initiated upon the medical provider□s order after the first clinical visit by the medical provider. Nursing will implement nursing interventions at admission for residents who have edema that include daily edema checks and daily weights. Unit managers will validate daily weights are completed and updates reported to medical provider during routine weekday chart reviews. The Director of Nursing or designee provided education the week of January 24, 2022 to licensed nurses on management of CHF and edema and notification of medical provider of changes in weight or edema. The Director of Nursing or designee provided education	

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F 684	Continued From page 14 beginning 1/3/22. Further review of R108's physician's orders revealed no orders for monitoring his edema, or any treatments to managing his edema. R108's care plan, included, "Resident with CHF, potential for alteration in vital signs," beginning 12/28/21. The approaches included, "Monitor for increased edema and significant weight changes and report to NP/PA/MD [Nurse Practitioner/Physician's Assistant/Physician] if occurs." "Protect resident from injury/trauma," and "weights as ordered," beginning on 12/28/21. The care plan did not specify what constituted a significant weight change. R108's Care Guide for Unit B, where R108 resided and provided by the facility on 1/5/22, revealed R108 was, "at risk" for skin impairment, with no actual impairment. Further review of the Care Guide revealed no mention of R108's edema or location of his edema, or the use of compression stockings. R108's weights, identified he weighed 210.3 pounds on 12/29/21, 213.7 pounds on 12/20/21 (a gain of 3.4 pounds in one day), and 216 pounds on 12/31/21 (a gain of 2.3 pounds since the previous day and 5.7 pounds in 48 hours). Further review of R108's weights revealed no further weights were taken prior to 1/4/22 when his weight was 217 pounds. R108's nursing progress notes, dated 1/2/22, at 5:23 a.m. included, "Resident c/o [complained of] left leg pain during the night. Ted [compression] stockings were removed from both legs as they had rolled partially down each leg and the elastic was constricting each leg leaving grooves and	F 684	the week of January 24, 2022 to licensed nurses, trained medication assistants, and certified nursing assistants on the need to ensure orders for compression stockings or wraps are in place prior to applying these to residents. The Director of Nursing or designee will complete audits of daily weights daily for four weeks, three times weekly for four weeks, then weekly for four weeks. Results of audits will be submitted to the facility Quality Council for Performance Improvement for review and recommendations.	

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causing the fluid to be trapped below the elastic. Both legs and feet have +2 pitting edema." Further review did not reveal whether the resident had an order for compression stockings, or if the physician was notified of the pitting edema.

R108's progress notes dated 1/3/22, at 3:36 a.m. included, "Nurse was assisting resident back to bed during night when resident requested lotion be applied to lower extremities. Nurse then discovered skin breakdown and blistering/weeping of right lower leg. One wound and one major blister with other smaller blisters surrounding, drainage scant and from blister which is mostly intact. Foam dressings applied to these areas. Resident has compression stockings from home he has been wearing while at facility, he does not have current orders for compression stockings or wraps at facility."

R108's Nurse Practitioner progress notes dated 1/3/22, included, "2 blisters on the right lateral lower extremity that have burst under draining clear fluid now." The note did not specify what the blisters burst "under."

R108's general orders dated 1/3/22, included, once daily dressing changes to wo open areas on his right lower extremity.

R108's progress note dated 1/5/22, included, "Received orders for compression wraps to BLE [bilateral lower extremities] and foam dressings to open areas to RLE [right lower extremity]. Larger open blister area on right shin measured today 5 cm [centimeters] x [by] 2.5 cm, smaller open blister area next to it measures 3 cm x 2 cm."

R108's Physician progress note for R108 dated

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1/5/22, included the physician was not informed of R108's weights on 12/29/21, 12/30/21, or 12/31/21. Further review revealed, "Bilateral lower extremity edema up to the knee level. He was weeping from the right lower extremity with 1 new blister anterior . . . on the right lower extremity. He has others that have burst . . . he does have bilateral lower extremity edema and his weights, although variable over the past 48 hours are certainly up - I suspect most of the weight is in his LEs [lower extremities]. It is possible he is up about 10 lb [pounds] post hospitalization . . . It is possible he will need IV diuresis if this weight trend continues . . . We will need to go to twice daily dressing changes, or more frequently if needed to the right lower extremity to control the edema soakage . . ."

When interviewed on 1/4/22, at 2:07 p.m. R108 stated he had, "some blisters or something" on the back of his right leg, which he stated were new within the past two days and causing him some discomfort.

During interview and observation with R108 in his room on 1/5/22, at 4:46 p.m. revealed R108 sitting in his wheelchair. His lower extremities were visibly swollen and loosely wrapped with a compression bandage. Compression stockings were in the resident's room, draped over the arm rest of a recliner in his room. The resident pointed at the stockings and stated, "I don't wear those. I don't know where they came from, but they hurt. They're garbage as far as I'm concerned, and you can take them with you."

When interviewed on 1/5/22, at 5:33 p.m. nursing assistant (NA)-F stated, she was assigned to care for R108 that shift. NA-F stated

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that she worked for a staffing agency, rather than the facility itself, so was not familiar with R108. NA-F stated that she would refer to her Care Guide for information on that resident. NA-F referred to the B Unit Care Guide and stated that R108 was, "at risk for skin problems but doesn't have any skin problems right now." NA-F stated the facility provided her with the Care Guide, which she carried with her and used as a reference when providing care, since she did not have access to resident care plans as an agency staff member. Review of the Care Guide revealed columns for resident room numbers and names, transfer status, devices such as dentures or glasses the resident used, toileting status, assistance needed for Activities of Daily Living (ADL's). whether the residents were "Skin/Fall Risk," and "Important Preferences."

When interviewed on 1/6/22, at 11:13 a.m. NA-E stated he had worked with R108 in the past, but was not aware of any edema or if he wore compression stockings. NA-E stated that as a facility employee he could access both the care plan in the EMR and the Care Guide used by agency staff, but those two documents did not typically match one another.

When interviewed on 1/6/22, at 2:41 p.m. licensed practical nurse (LPN)-D stated R108 did not have any open areas to his skin prior to 1/3/22, at that time it was discovered he was wearing ted stockings without an order and had developed blisters.

When interviewed on 1/6/22, at 4:18 p.m. R108's medical doctor (MD)-A stated, it was her expectation that any resident admitted to the facility with a diagnosis of CHF would be placed

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on a "CHF Protocol" which included both daily weights and skin assessments. The MD stated that daily weights were the facility's primary mode of monitoring CHF so long as they were taken before breakfast each day and using the same scale for accuracy. The MD stated that the facility had not reported R108's almost 6-pound weight gain in 48 hours between 12/29/21 and 12/31/21 to her office, which she would have expected as part of the "CHF Protocol." The MD stated that in R108's case he had been admitted from a different hospital than the facility was accustomed to working with, and she had been on vacation at the time the resident was admitted, so somehow the "CHF Protocol" did not get initiated. The MD stated that the facility should not have placed compression stockings on the resident without a physician's order and that when she first examined R108 on 1/5/22, his edema was such that she would not have ordered compression stockings because he had, "significant edema, to the point of weeping," and, "there was too much edema to apply them safety without causing skin damage or discomfort." The MD stated that R108 would have been unable to don his own compression stockings given the amount of edema he had.

When interviewed on 1/7/22, at 8:19 a.m. the director of nursing (DON) stated, he was not sure how R108 came to have compression stockings in his room, or who had applied them on 1/2/22 or 1/3/22. The DON stated, the facility was using agency staff to cover many shifts during this time, so it was difficult to tell who had provided care for R108 on those nights. The DON stated he presumed family had brought the compression stockings from home, but the staff should not have placed the stockings on R108 unless it was

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a physician's order and/or the stockings were on R108's care plan. The DON was asked to provide the facility's policy for Edema Management, as well as the "CHF Protocol" referenced by R108's MD. At 10:11 a.m. the DON stated, "technically" agency staff did have access to the care plans in the EMR, but the facility provided the Care Guide as a shortcut so they could provide care with a limited amount of orientation to residents. The DON stated that he updated the Care Guides on a spreadsheet in his computer daily and distributed them to the nurse's stations.

When observed on 1/7/22, at 10:11 a.m. with family member (FM)-B, and LPN-D, FM-B stated R108 had used compression stockings at home in the past, but his edema became so much the stockings were too tight, for about 2 months prior to hospitalization and nursing home admission. FM-B had been wrapping his legs with compression bandages instead. FM-B stated she had not brought the stockings that were draped over a chair in his room, in for him.

R108's wound care progress note dated 1/7/22, at 11:41 a.m. included, "Continues to have 2+ pitting edema of BLE (bilateral lower extremities) from toes to mid shin." "Right lower anterior had one open area and two smaller areas." The measurements were right lower anterior 1.1 cm. x 1.0 cm x 1.0 cm. The Superior anterior shin wound measured 2.2 cm x 1.2 cm x 0.1 c.m. The lateral right lower leg, "does not appear to have one large wound but now has area with pin point area within it. Total area 5.0 cm x 3.0 c.m. with pinpoint weeping areas throughout."

When interviewed on 1/7/22, at 10:31 a.m. the administrator stated, it was his expectation that

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the facility would identify CHF as a diagnosis for a resident at the time of admission, and if orders for the "CHF Protocol" were not present, then the nurse would notify the physician. The administrator stated it was his expectation that staff would not apply compression stockings without a physician's order. The administrator was asked to provide copies of the facility's Edema Management Policy and CHF Protocol. The administrator deferred these requests to the DON. The Administrator stated it would be his preference that all staff accessed the care plan in the EMR rather than try to keep a second Care Guide document that had to be updated separately, and he would work with his leadership team to, "make it happen."

When interviewed on 1/7/22, at 12:41 p.m. the DON stated the facility did not have an edema management or CHF protocol.

R114's Face Sheet, undated, identified an admission date of 12/22/21, and a diagnosis of CHF. R114 did not have an MDS assessment completed at the time of the survey.

R114's Physician orders dated 12/23/21, included and order to weigh daily, before breakfast, use the same scale every day. The physician was to be notified for weight gain greater than 2.5 pounds in 48 hours, or 5 pounds over admission weight. Dry weight was noted to be 274 pounds. The physician was also to be notified if weight was over 280 pounds or under 268 pounds.

R114's weights since admission were documented as:
On 12/22/21, R114 weighed 280.8.
On 12/23/21, R114 weighed 282.8 (2.8 pounds

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F 684	Continued From page 21 over 280, defined as a notification point in the physician's orders) On 12/24/21, R114 weighed 280.8. On 12/25/21, R114 weighed 280.0. On 12/26/21, R114 weighed 248.8 (no explanation for this weight being 31.2 pounds down from the previous days' weight) On 12/27/21, R114 weighed 285.6 (warranting physician notification for being over 280 pounds and a gain of greater than 2.5 pounds in 48 hours) On 12/28/21, R114 weighed 286.3. On 12/29/21, R114 weighed 285.6. Review of R114's EMR, did not contain documentation that R114's physician was notified of weight variances on 12/23/21, 12/26/21, 12/27/21, or 12/28/21. When interviewed on 1/7/22, at 9:07 a.m. the DON stated, the physician should have been notified of R114's weight changes. At 1:26 p.m. the DON provided documentation R114's physician had been notified of weight changes on 12/22/21, 12/29/21 and 1/3/22. However, the physician had not been notified of the weight changes 12/23/21, 12/26/21, 12/27/21, or 12/28/21.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		2/2/22

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F 689	Continued From page 22 accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, facility failed to clearly communicate and implement fall prevention interventions for 2 of 2 residents (R204 and R45) who had recently fallen in the facility. Findings include: R204's admission Minimum Data Set (MDS) dated 12/23/21, was completed upon return from hospitalization on 12/17/21. The MDS indicated R204 had moderately impaired cognition and required extensive assistance of two persons with bed mobility, and did not stand or walk at that time. R204's diagnosis list included a history of recent falls, a recent fracture of his right ischium (lower part of pelvic bone under buttock muscles), dementia, secondary parkinsonism (similar to Parkinson's disease with tremors, stiffness, slow and reduced movements), among many other co-morbidities. R204's electronic health record (EHR) care plan indicated a problem, start date 12/17,21, "resident at risk for falling R/T [related to] unspecified fracture of right ischium, Parkinson's dse [sic], weakness. The goal for this problem area dated 12/17/21, "resident will remain free from injury." The interventions listed included, "12/17/21 keep call light in reach at all times" and "12/17/21 PT/OT as ordered", "12/25/21 offer resident to lie down for a nap after meals", and an additional intervention was added 1/7/22, "W/C [wheelchair] next to bed while in bed." A problem dated 12/17/21 indicated, "I have a self-deficit with the following activities of daily living; bathing,	F 689	F689 R204 care plan reviewed and revised on January 7, 2022. R45 care plan reviewed and revised January 5, 2022. The interdisciplinary team completed a falls risk assessment and root cause analysis on previous falls for R204 and R45 the week of January 24, 2022 with updates to care plan if indicated. Residents who experience falls have the potential to be impacted by the alleged practice. Residents who have had falls since January 7, 2022 were reviewed the week of January 24,2022 by the interdisciplinary team with root case analysis completed and care plans updates implemented based on root cause. The interdisciplinary team will continue to review falls during interdisciplinary meetings to determine root cause and implement effective falls reduction interventions. The falls policy was reviewed and remains current. The use of the Falls Checklist with Huddle will be implemented at the time of fall to ensure falls investigation includes information that is useful in determining root cause. The Director of Nursing or designee provided education the week of January 24, 2022 to licensed nurses, trained medication assistants, and certified nursing assistants on the Falls Checklist with Huddle to assist in determining the root cause of the fall based on contributing factors. This education	

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F 689	Continued From page 23 grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder." Listed interventions included, "I require assist of 2 to assist me with transfers with EZ stand," updated/changed on 1/7/21 to read, "I require assist of 1 with FWW [front wheel walker] for transfers." However, the care plan maintained the following two interventions listed separately, "12/17/21 I require assist of 2 to get my toileting needs addressed", and "12/17/21 Using assistive devices can help me better take care of my deficits. I use: EZ Stand [mechanical device to assist with standing] with A x2 [assist of two persons]." A paper document, "care guide" updated on 1/6/22, indicated R204 transferred with the assist of one person and a FWW, but did not walk. The care guide indicated R204 was a fall risk, but did not provide any indication of safety interventions. The following statement was printed at the top of the guide: "Important Notice: Please do not rely solely on these Care Guides. Please refer to resident Care Plan or Profile for more accurate and up to date information. The Profile can be accessed from POC [point of care, a documentation site in the EHR primarily for nursing assistants] by clicking on "Resident Profile" in the upper right corner of POC." An event report dated 12/12/21 indicated R204's call-light was on, but staff found him on the floor in his room sitting against the bed. He was sent to the emergency room for respiratory symptoms at that time. No further assessment of the events leading up to the fall or interventions related to the fall were found documented. A Fall Risk Acuity, balance and functional	F 689	included the need for the licensed nurse to implement an immediate intervention based on the information collected during the completion of the falls checklist. The Director of Nursing or designee will complete audits of fall documentation and care plan interventions three times weekly for four weeks, twice weekly for four weeks, and then weekly for four weeks. Results of audit will be forwarded to the facility Quality Council for Performance Improvement for review and recommendations.	

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limitation observations was completed for R204 on 12/17/21. The document indicated a score greater than ten represented a high risk for fall. R204 was assessed to have a score of 17. The section of the form for a, "fall risk summary-identify risk factors that may contribute to the resident fall risk, including medications and environmental risk factors," contained no documentation. The referrals listed that, "may be appropriate" were checked as OT (occupational therapy) and PT (physical therapy). In the section titled: Plan of Care, the following was documented: "indicate care plan action taken: continue current plan of care."

An event report dated 12/20/21 indicated R204 had an unwitnessed fall at 4:14 a.m.; was found by a nursing assistant responding to his call light but he was laying on the floor next to the bed. The immediate intervention chosen was, "rest," no additional interventions documented including after IDT review to aid in preventing this type of fall from happening again.

An event report dated 12/25/21 indicated R204 had an unwitnessed fall at 10:54 a.m. in his room, and he had said he was getting himself into bed. No immediate interventions were listed as having been implemented except to say he would continue to be monitored. He was noted to have been already participating in therapy services at that time.

An event report dated 1/2/22 indicated R204 had an unwitnessed fall in his room at 12:25 a.m. He was found on his bedroom floor. The immediate intervention was observation, and a note indicated "post fall monitoring in place along with interventions added to care plan." No additional

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interventions documented.

A progress note written in R204's EHR on 1/3/22, 1:14 p.m. included the following: "IDT f/u [follow up] fall on 12/12, 12/20, 12/25 & 1/2/21 [sic]: On 12/12, resident fell around 2:50 am call light was on and was answered promptly. He was found by the nurse sitting on his bottom with his back resting against his bed. No injuries noted. On 12/20, at 4:15 am resident was found lying on his right side, on the floor next to the bed. Resident denied any pain. No obvious injuries were found. On 12/25, resident was on the floor, assessed for injuries. None noted. On 1/2/22, resident found laying on back upon bedroom floor around 12:25 am. Resident denied pain, VS WNL (vital signs within normal limits), and ROM (range of motion) per resident's baseline. Resident is at risk for falls d/t [due to] history of repeated falls, schizotypal disorders (a personality disorder that may include paranoia, odd or unusual thoughts), Parkinsonism & dementia with Lewy bodies (proteins in brain affecting memory and thought). Most recent BIMS {cognitive assessment] is 9 indicating moderate impairment. RCA (root cause analysis): impaired gait/balance and poor safety awareness. Interventions include: Resident being sent to ED for evaluation of underlying health conditions, fall mat at bed side, lie resident down after meals and observe frequently and place in supervised area when out of bed."

On 1/05/22, 3:21 p.m. R204 was observed in bed in his room, only the foot of the bed was visible from the door. After entering, was observed to be positioned somewhat on his right side using pillows and a soft touch call light in bed. The bed was at a standard height and wheelchair located about six feet away, facing away from him. A

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bedside table was positioned next to the bed. R204 had a moist cough, kept his head extended backward and mouth open. He was not able to answer questions at that time.

1/06/22, 10:42 a.m. R204 was observed in his room sitting up in w/c, not able to be seen from hall.

During an interview on 1/6/22, 10:50 a.m. a nursing assistant (NA)-B stated staff would know how to care for the residents if they were familiar and experienced at the facility, and the way to learn was to follow other staff and learn from them. NA-B said there was a paper care guide available, but was not able to describe how to access the EHR care plan when asked despite the notice on the care guide. NA-B was observed to be documenting in the EHR POC system at the time. NA-B said she sometimes trained the new or contracted "pool" staff.

On 1/6/22, 10:59 a.m. NA-A, a "pool" staff, described the "care plan" as a piece of paper that would describe how to transfer a resident, move them in bed and "all that type of thing." NA-A also said, "after a while you learn them [resident cares]." NA-A stated R204 required the assistance of two persons to transfer. NA-A said the "care plan" indicated R204 was a fall risk and reported the following interventions to prevent falls as she knew them, "well, we put him in bed, and make sure he is positioned right, put his head up because he has trouble swallowing and needs to sit up. And we have to watch him, like if he turns on his light to go to the bathroom, stay, don't leave him."

During an interview 1/07/22, 7:15 a.m. a licensed

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practical nurse, (LPN)-A stated she usually worked the evening and night shift, and confirmed that R204 had had several falls during the night. LPN-A said there were paper sheets that were a guide for nursing assistants and the more experienced staff would help those who were new. LPN-A stated R204 was quite impulsive, did not use his call light, and said to prevent falls, persons working on the night shift would tuck a pillow under his right side which would remind him not to get up without help, and they would place his call-light under it so his weight would turn on the call-light. LPN-A thought R204 would benefit from having a fall mat on his floor and had reported this, but said she had never heard back and was unsure how decisions were made in relation to fall prevention. She stated she knew pressure alarms were noisy, but thought it would help R204, and was unsure of why they were no longer used, and also stated, "I miss side rails." LPN-A did not update care plan interventions and confirmed her recommendations were not listed on the care plan or care guide.

On 1/07/22, 8:46 a.m. LPN-C stated their overall team would discuss care plan interventions, and the Interdisciplinary Team (IDT) would meet after fall incidents to decide on appropriate interventions, especially for safety which would vary depending on the resident. LPN-C was unsure if night staff were involved in this process, but night shift were to attend a meeting on a monthly basis where they would receive information about any care plan changes. LPN-C said, as a clinical manager, she was responsible to update the care plan for R204 and other residents on the same unit. LPN-C said R204 should not have a fall mat because he might get up unassisted now that he was actively

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transferring with the assist of one at all times, and walking with therapy. Instead, LPN-C said R204 should have his W/C at his bedside with the breaks locked in case he would attempt to get up; however, LPN-C confirmed the EHR care plan did not indicate this was the appropriate intervention, nor did the care guide. LPN-C said she was going to update the care plan immediately as it was incorrect. LPN-C stated nursing assistants should be following the paper care guide, and confirmed R204's care guide did not match the EHR. LPN-C said clinical managers were responsible to update the care guide as well as the care plan in the EHR.

On 1/07/22, 9:42 a.m. the director of nursing (DON) stated information for safety interventions related to falls would vary according to the resident, and the full IDT team met every Wednesday to discuss any issues, but the facility would rely on the entire team to give input. DON said a meeting was held each month and staff were to attend, but for the best continuity of care, the nurses on the floor should communicate directly with the clinical managers, but that nurses or clinical managers could update the care plan. Also, if the IDT made recommendations the clinical managers were expected to talk to the nurse working on the unit who were then to share with the rest of the staff. DON also stated an expectation for appropriate interventions to be added to the care plan as soon as possible, and the care guide to also be updated as soon as possible. DON stated ideally the care guide and care plan should be matching. DON said the care guides had been designed for contracted pool staff to use for easy reference, but he had an expectation for those permanently hired to use the EHR care plan for a more complete listing of

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cares.

A facility policy titled Comprehensive Assessments and Care Planning, not dated but with a copyright of 2017, was provided. The policy outlined the process of completing assessments and updating care plan using the guidelines for the standard MDS upon admission, readmission, quarterly or when there is a significant change. The policy indicated the Care Area Assessments (CAA) would be used to develop the comprehensive care plan, saying: "the facility will use the findings from the CAA process as a starting point for developing the resident's comprehensive plan of care. Note: the facility is responsible for addressing the needs and strength of the resident weather [sic] or not it is included in the CAA process." The policy did not provide information on how to maintain accuracy when changes occur between assessment periods, or how to maintain continuity between the EHR and the handwritten care guides.

A facility policy titled Integrated Fall Management, not dated but with a copyright of "20xx", was provided. The policy indicated, "Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort." In addition, the policy indicated, "Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment."

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Review of the facility's undated, "Integrated Falls Management" policy revealed, " ... A Fall Risk Assessment is completed ... within 48 hours of admission to the facility ... Residents at risk for falls have an individualized resident centered care plan developed ... "

R45's Face Sheet identified, he was admitted to the facility on 11/23/21 and re-admitted on 12/01/21 with diagnoses which included COVID-19, Congestive Heart Failure (CHF), chronic respiratory failure with hypoxia (lowered concentration of oxygen in the blood), Type 2 diabetes mellitus, muscle wasting and atrophy, unsteadiness on his feet, and repeated falls.

R45's Fall Risk assessment, dated 11/23/21, identified fall risk factors included neuromuscular and functional impairment such as decline in functional status, hypotension, or syncope; impaired balance; range of motion impairments in both of his upper extremities; and the use of anticoagulant, antihypertensive, diuretic, and narcotic medications.

R45's care plan dated 11/23/21, included a problem area for fall risk, the only approach to prevent falls was to keep the call light in place.

R45's progress notes dated 11/25/21, at 2:45 a.m. included he had been sent to the hospital for shortness of breath and chest pressure.

R45's progress notes dated 12/1/21, at 12:00 p.m. identified he had returned from the hospital where he had been for fluid overload, COVID-19 infection, weakness needing a mechanical lift and to assist R45 out of wheel chair and into bed. R45 had muscle spasms and tingling in lower

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extremities.

R45's medical record did not include a new fall risk assessment with his change of condition. R45's care plan had not been updated regarding increased need for assistance or fall interventions.

R45's progress note dated 12/2/21, at 5:12 a.m. identified, R45's knees were buckling, had an unsteady gait and transfer needs were to be re-evaluated.

R45's Event Details report dated 12/2/21, at 12:57 p.m. identified, "Staff heard resident calling for help, and found him laying on the floor in the prone position." "Resident stated he was sitting on the side of the bed and fell forward." Immediate intervention was listed as: "he was encouraged to not sit at the side of the bed, which he agreed to do and demonstrated verbal understanding," and a work order put in for bed with grab bars and bariatric recliner.

R45's care plan had a new fall prevention approach added on 12/2/21, "I have been encouraged to not sit on the edge of the bed."

R45's admission MDS dated 12/7/21, identified cognitively intact need for extensive assistance of 2 for bed mobility and transfers, did not ambulate, was not stead and had experienced one fall with injury since admission.

R45's care plan added the fall intervention on 12/9/21, of grab bars and bariatric recliner.

R45's progress note dated 12/15/21, at 8:22 a.m. included, "Resident legs are bending, lifting,

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moving outside of the resident's control ... Therapy/nursing is concerned about potential spinal stenosis as the cause for the movements being observed. His arms are also weak."

R45's progress note dated 12/21/21, at 2:22 p.m. identified the nurse practitioner wanted R45 seen at emergency department. Another progress note dated 12/22/21, at 1:19 a.m. identified R45 had been returned to the facility with no new orders.

R45's progress note dated 12/29/21, at 3:51 a.m. included, "heard someone yelling 'help' down the hallway ... noticed resident on floor facing down ... deep laceration to the left upper portion of his forehead with a moderate amount of blood on the floor and continuing to bleed ... Resident stated that he had a spasm and his trunk flew forward. Call light was not on but was within reach." Further review of this progress note revealed Emergency Medical Services (EMS) were summoned and the resident was sent to the ED for treatment of the laceration.

R45's care plan had a new approach to prevent falls added on 12/31/21, of, "I have been encouraged to sleep in bed and not my [wheelchair]."

During observation and interview with R45 on 1/4/22 at 9:29 a.m. R45 was sitting in wheelchair in his room with his overbed table pulled close to abdomen. R45 had a reddish colored scar on his left eyebrow, and a second upside down L-shaped scar extending from between his eyes above his nose, across his forehead to above his left eye just below his hairline. The L-shaped scar appeared to be from a laceration which had been sutured. R45 stated the scars were from falls he

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had in the facility. The resident stated that the first fall, which resulted in the scar on his eyebrow, had been because he became fatigued and fell forward while sitting on the edge of his bed, and the second had been when he had a spasm while sitting in the wheelchair and fell forward onto his face. R45 stated that after the second fall he was sent to the hospital for sutures. R45 stated he continued to experience spasms daily. R45 stated the facility had not implemented any measures to prevent further falls as far as he knew, but he had taken it upon himself to pull his wheeled overbed table snugly to his abdomen while he was sitting in his wheelchair as he believed that would prevent him from falling should he experience another episode of fatigue or a "severe" muscle spasm.

When interviewed on 1/5/22, at 5:40 p.m. NA-F stated she had been assigned to care for R45 since 6:00 a.m. NA-F worked for a staffing agency and was not familiar with R45's needs. She had a care guide provided by the facility and used that as a reference. Review of the "Care Guide" revealed columns for resident room numbers and names, transfer status, devices such as dentures or glasses the resident used, toileting status, assistance needed for Activities of Daily Living (ADL's). NA-F stated that because she worked for a staffing agency, and not the facility itself, she could not access individual resident care plans. NA-F consulted the Care Guide in her pocket, then stated that R45 was at risk for falls. When asked what that meant, NA-F stated that it either meant that she had to "check on him every 15 minutes or so" if he was confused or had to "respond quickly to his call light" if the resident was alert and oriented. NA-F stated that she was unable to tell which applied to

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R45 without looking at him. The surveyor accompanied NA-F to R45's room, where R45 was sitting in his wheelchair with his overbed table pulled snugly in front of his abdomen. NA-F stated R45 was alert and oriented so she did not have to check on him more frequently than every two hours but should respond quickly if the resident activated his call light. NA-F stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair in his room.

When interviewed on 1/5/22, at 5:45 p.m. R45 stated he had a recliner in his room, but was currently sitting in his wheelchair. R45 stated the facility had brought in the recliner at some point, which may have been after his first fall, but did not instruct him to use it as a preventive measure against further falls and, "It wouldn't work anyway. I can't lift the footrest." R45 stated the facility wanted him to sleep in his bed and not the recliner or the wheelchair, but he found that difficult because he liked his head elevated to make it easier to breathe. R45 stated sometimes he ended up sleeping in the recliner without the footrest up, which felt "a little more secure" than his wheelchair, but he was concerned another spasm could result in falling from the recliner unless the footrest was up. R45 stated staff typically checked on him "every couple of hours" unless he put his call light on, which would be fine "unless I have another spasm that causes me to fall." R45 stated it was his expectation that staff caring for him would be knowledgeable about his fall history and checking on him frequently to ensure his safety.

When interviewed on 1/6/22, at 11:16 a.m. NA-E stated he regularly cared for R45. NA-E stated

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F 689	Continued From page 35 that he was aware R45 had fallen in the past but did not consider him to be a current fall risk because "he's total assist with almost everything." NA-E stated there were no special precautions staff had to take to prevent falls for R45 and checking on him every two hours was sufficient. When interviewed on 1/7/22, at 8:30 a.m. the director of nursing (DON) stated, he considered R45 a fall risk based on his history of falls in the facility. The DON stated that the location of R45's room, which was "right in the middle of the hall" resulted in increased supervision, and that staff were also encouraging frequent position changes and offering to lay R45 down. When asked about NA-F's lack of familiarity with R45's fall history or any precautions she should be aware of when caring for R45, the DON stated, "Well she's a pool [staffing agency] CNA [Certified Nursing Assistant], so I would not expect her to have the same depth of information that someone on our own staff would have." The DON stated R45's recliner should be used, "In the reclined position if he is taking a nap or resting," and R45 was using it that way as far as he knew.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		2/2/22

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F 692	Continued From page 36 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the facility failed to ensure the prescribed therapeutic diet was followed for 2 of 2 residents (R3 and R204) reviewed for therapeutic diets; resulting in the potential for choking, aspiration and weight loss to occur. Findings include: R3's Face Sheet, undated, indicated an admission date in August 2019 and readmission 11/4/21. Diagnoses included, diabetes, dysphagia (difficulty swallowing), depression and chronic pain. R3's quarterly Minimum Data Set (MDS) dated 12/15/21, identified R3 was cognitively intact and did not have signs or symptoms of a swallowing disorder. R3's physician orders directed staff to provide a pureed diet and was dated 11/10/21. When interviewed on 1/4/22, at 10:30 a.m. R3 stated, "I am supposed to be on a pureed diet, but lately they have been sending me regular food." R3 stated she was on a pureed diet due to dysphagia difficulties. R3 was evaluated by the	F 692	F 692 R3 Informed Consent process reviewed with resident by Speech Language Pathologist on January 6, 2022. Resident will receive puree foods and can request non-puree foods as desired. Medical provider was updated on resident choice to request non-puree foods as desired. Nutrition care plan is updated. Culinary staff have received training on following therapeutic diets. R204: The Ensure Clear supplement was changed to Ensure Plus and has been flow tested per IDDSI criteria to verify compliance with Nectar thick fluids. Residents who receive altered texture diets or thickened liquids have the potential to be impacted by the alleged practice. A comparison of diets entered in meal suite and orders entered in the electronic health record and data base was updated if needed based on review and comparison. The policies for altered texture and thickened liquids was reviewed and remains current. The dietary manager provided training to	

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F 692	Continued From page 37 speech language pathologist (SLP) on 11/09/21 and determination was made for the pureed diet. The SLP made recommendation to R3's physician who agreed and implemented the order on 11/10/21. During an observation on 1/4/22, at 11:50 a.m. of R3's lunch meal, R3 received chicken and rice that appeared to be a ground texture and not pureed along with three pieces of whole cauliflower florets. R3 stated "I tried to eat the chicken and rice and it didn't go down very easy." The dessert was a blueberry bar (cake like texture) that R3 ate in this surveyor's presence and stated it went down fine. Liquids were served regular consistency, as per the current diet order. The meal ticket on R3's tray was noted with pureed diet circled. During an observation on 1/5/22 at 11:30 a.m. R3's lunch meal was observed delivered to her room at 11:25 a.m.. R3 was not in her room at the time. Observation of the lunch meal revealed a regular texture full taco salad with whole tortilla chips. No pureed items were noted on her tray. Tray ticket was observed and noted to have "pureed" diet circled. During an interview on 1/5/22, at 3:30 p.m., R3 stated she was unable to eat her entire taco salad. R3 stated she was unable to eat the lettuce, chips, and some of the meat due to the consistency. During an observation on 1/5/22 at 4:50 p.m., R3 had her dinner meal tray which was not pureed. R3 stated "I had mashed potatoes and cream of mushroom soup, but I couldn't eat the Spanish rice dish."	F 692	culinary staff on how to properly thicken fluids when commercially prepared thickened products are not available. Training was also provided on following the meal suite ticket when preparing plates for residents. The Director of Nursing provided training to the therapy staff and to licensed nurses on following diet texture orders and notifying the medical provider and completing the informed consent process for residents who choose not to comply with orders. The culinary director or designee will complete random meal audits. The frequency of these audits will be three times weekly for four weeks, twice weekly for four weeks, then weekly for four weeks. Results of audits will be forwarded to the facility Quality Council for Performance Improvement for review and recommendations.	

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During an interview on 1/6/22, at 3:30 p.m. with the culinary services director (CSD), registered dietician (RD), and director of nursing (DON); the CSD stated R3 frequently would go into the kitchen and "yell at the kitchen staff that she wants regular food and not pureed." However, both the CSD and RD stated those interactions were not documented in R3's chart and the CSD confirmed the current diet order for R3 was a pureed diet and that would be expected to be delivered to her. The RD stated she was not aware that R3 did not want a pureed diet and had not spoken with her to discuss any potential changes to her current diet. The DON stated that nursing should be documenting refusals for the pureed diet and communicating with the kitchen staff, CSD or RD for a review, or changes, to her diet.

R204's admission MDS dated 12/23/21, completed as a readmission assessment after hospitalization on 12/17/21, R204 had moderately impaired cognition, required the extensive assistance of one person for eating. R204's diagnosis list included dementia, secondary Parkinsonism (similar to Parkinson's disease with tremors, stiffness, slow and reduced movements, poor coordination) and dysphagia (difficulty swallowing foods and liquids) along with many other co-morbidities.

R204's care plan indicated a problem, start date 1/5/22, "I have ineffective breathing patterns related to: aspiration, as evidenced by : Dx [diagnosis] of dysphagia, coughing, pureed diet with nectar thick liquids]. Additionally, the care

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plan also contained a problem dated 12/10/21, "I have an alteration in nutrition/hydration status r/t to [sic] dx of dysphagia, hx [history] of aspiration events and need for mechanically altered diet order and assistance at meals." The goal stated: "provide diet as ordered (pureed texture with honey-thickened liquids 12/10/21) and recommended in accordance with ST [speech therapy]. On 12/10/21 the following intervention was added, "provide nutritional supplement: 8 oz Ensure clear (honey-thickened)."

A paper document "care guide" updated on 1/6/22 indicated that R204 had dysphagia and required a pureed diet with nectar thickened liquids.

According to R204's physician orders with a start date of 12/27/21, diet: dysphagia (pureed) Liquids: nectar consistency.

On 1/05/22, 3:21 p.m. R204 was observed in bed in his room, only the foot of the bed was visible from the door. After entering, was observed to be positioned somewhat on his right side using pillows and a soft touch call light in bed. R204 had a moist cough, kept his head extended backward and mouth open. He was not able to answer questions at that time.

1/06/22, 10:42 a.m. R204 was observed in his room sitting up in w/c, not able to be seen from hall; had half glass of thickened orange juice without a lid or straw and a glass of water with lid, but no straw sitting next to him on a bedside table. A boxed serving of Ensure Clear was also sitting on the table, the contents could not be observed, there was no indication if it was thickened and no straw was present.

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During an interview on 1/6/22, 10:50 a.m. a nursing assistant (NA)-B stated staff would know how to care for the residents if they were familiar and experienced at the facility, and the way to learn was to follow other staff and learn from them. NA-B said there was a paper care guide available, but was not able to describe how to access the electronic care plan.

On 1/6/22, 10:59 a.m. NA-A, said the care guide provided interventions for resident care. NA-A said it was important for R204 to be "positioned right, put his head up because he has trouble swallowing and needs to sit up".

At 1/06/22 11:04 a.m. NA-A was observed to enter R204's room where he was sitting in his wheel chair. NA-A told R204 it was time for his meal, but he pointed at the fluids sitting nearby on an overbed table. NA-A asked if he wanted his Ensure and R204 nodded. The Ensure Clear was observed in its original boxed container. NA-A placed a straw into the container and gave R204 a drink, and then took him to the dining area.

During an interview on 1/06/22, 11:08 a.m. a registered nurse (RN)-B looked at the container of Ensure Clear in R204's room and confirmed the container did not have any information related to its consistency. RN-B said, "well, it's definitely thicker than water, but I guess I don't know [consistency]." RN-B said she thought perhaps the people in the kitchen would know if the product was thickened. At that time NA-A re-entered the room and said, "he's taking it, he's taking it."

At 1/06/22, 11:12 a.m. a dietary aid (DA)-A stated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

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F 692	Continued From page 41	F 692		

Ensure Clear was not a pre-thickened product. Immediately after, the registered dietician (RD) stated an expectation for whomever was taking the product to a resident to use a thickener provided in the dining area as needed, following the written directions, before taking it to a resident's room.

At 1/06/22, 11:15 a.m. in R204's room, RN-B retrieved the Ensure Clear left in the room and poured approximately two ml into a clear plastic cup and compared the solution to R204's thickened juice and thickened water sitting on his bedside table. RN-B confirmed the Ensure Clear appeared to be more liquid in nature than the other two beverages, and stated it did not appear to be "nectar thick."

During an interview 1/06/22, 1:51 p.m. the RD said nursing assistants or dietary could thicken liquids, stating it was the responsibility of nursing staff to thicken any liquid to match the orders if they were the one bringing it to a resident who requires thickened liquids. RD was not able to say how a person would know R204's Ensure Clear had already been thickened if they found it in the room. RD stated a concern in providing non-thickened liquids to R204 as it might make his dysphagia "act up." The Culinary Services Director who had been listening stated, "that's a problem. We should do something. It should be poured into a glass if you don't know."

On 1/06/22, 2:41 p.m. the DON stated it was the responsibility of the culinary services to obtain the correct product for persons who require thickened liquids, and they were the ones who would know who had the ability and training to prepare it. DON stated nursing assistants should know that

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F 692	Continued From page 42 thickened liquids are required by looking at the care plan or care guide, but the liquid should come in the proper state from the kitchen. DON said a nurse might thicken liquids if they were able to read and understand the package instructions. DON confirmed that only the person who had prepared the Ensure Clear for R204 would be able to know if it had been thickened as it was not visible through the container. On 1/07/22, 9:57 a.m. the DON stated a new order for Ensure Plus had been received for R204. DON then said, the only persons who could mix thickened liquids were dietary staff, and not nursing staff, and this was not a new policy. A facility policy titled Thickened Liquids, not dated but with a copyright of 2012, indicated "residents receive thickened liquids per a physician's order which specifically states the consistency of the thickened liquids. It is the responsibility of all staff to ensure that the resident receives all liquids in the appropriate consistency to prevent aspiration while promoting adequate hydration." The consistencies matching those used at the facility were described as: nectar thick-consistency of thin milkshake or eggnog, honey-consistency of honey at room temperature or a thick milkshake or pudding thick-consistency of pudding and does not run off a spoon. The responsibility of thickening liquid was described as "culinary services will be responsible for providing thickened liquids for meals and nourishments and commercially prepared products that are used for medication administration. In addition, the policy indicated the need for thickened liquids should be documented on the resident care plan.	F 692		
F 880 SS=D	Infection Prevention & Control	F 880		2/2/22

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F 880	Continued From page 43 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 44 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure proper hand hygiene while caring for 1 of 16 residents observed for personal cares. Findings include: Review of the facility's "Hand Hygiene" policy, dated June 2017, revealed, " ... Times to Perform Hand Hygiene are, but not limited to ...	F 880	F880 R204 has been free of signs and symptoms of infection following the observations on January 4, 2022. Residents who receive assistance with meal delivery, set up, or assistance with eating meals have the potential to be impacted by the alleged practice. The staff member involved in this observation was educated on hand hygiene, glove	

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F 880	Continued From page 45 Before and after direct resident contact ... Before and after assisting a resident with meals - wash hands with soap and water ... After contact with a resident's mucous membranes and body fluids or excretions ... " Review of R204's "Face Sheet," located under the "Face Sheet" tab of his electronic medical record (EMR), revealed he had been most recently admitted to the facility on 12/17/21 with diagnoses which included dysphagia, Lewy body dementia, need for assistance with personal care, and need for continuous supervision. Further review of R204's EMR revealed no Minimum Data Set (MDS) assessment had been completed at the time of survey. Observation of R204 on 01/04/22 between 11:32 AM and 12:12 pm. R204 was sitting in his wheelchair at a table in the dining room and was approached by the Speech Therapist (ST). The ST did not perform hand hygiene before approaching the resident. The ST was carrying an electronic tablet, which she placed on the table near R204, then crossed the room to the serve-out kitchen where she obtained two bowls of food. The ST had not performed hand hygiene and was not wearing gloves. The ST grasped each bowl by placing her thumb and index finger on each side of the rim, with her thumb inside the bowl, to carry them across the room to R204. The ST used R204's spoon to stir the contents of one of the bowls, then placed a spoonful of food into his mouth. The resident began coughing and she picked up his cloth napkin which she used with her bare hand to cover his mouth. When R204 was no longer coughing, she left the table and, without performing hand hygiene, went into the ante area of the serve-out kitchen where she	F 880	use, and following infection control principles when carrying containers of food and completed a hand hygiene competency and post test the week of January 24, 2022. An ad-hoc Quality Council meeting was held on January 24, 2022 to analyze root cause of failure to complete hand hygiene and comply with glove use. Signs were posted in dining areas and near serving stations to remind staff of the need to complete hand hygiene. Availability of hand hygiene products and gloves in the dining area was reviewed and products placed in key areas in dining room. Hand hygiene policy was reviewed by the Director of Nursing/Infection Preventionist and remains current. The Director of Nursing or designee provided education the week of January 24, 2022 to the interdepartmental staff on hand hygiene and avoiding touching food or inside of food containers when delivering meals. The Project Firstline Team Table Talk video on Hand Hygiene was presented for educational purposes. Resources from the CDC on Hand Hygiene were also presented. The Director of Nursing or designee completed hand washing competency with interdepartmental staff and reviewed Hand Hygiene guidelines with interdepartmental staff. The Director of Nursing or designee will complete audits of hand hygiene on each shift daily for seven days and based on the results of these audits will continue monitoring daily until compliance achieved, or if compliance is noted,	

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F 880	Continued From page 46 obtained several small cartons of beverages. The ST placed all but one of the cartons in a reach-in refrigerator in the serve-out kitchen then returned to R204 with the remaining carton. R204 began to cough, and the ST picked up his cloth napkin to cover his mouth. After assisting the resident with a few bites from his bowl, the ST obtained two tissues from a dispenser on the table, handed them to R204 and instructed him to blow his nose. R204 blew his nose as instructed then placed the used tissues on the table next to his plate. The ST continued to assist R204 in this manner throughout the meal. The ST was touching her face to push up her glasses throughout the observation. At 12:03 PM, R204 began to cough more persistently and with more intensity. The ST responded by using first her bare hands, then his cloth napkin, then the soiled tissues with which R204 had blown his nose to cover his mouth. While other staff assisted R204 from the table, the ST went to the hand washing sink at the edge of the dining room where she washed her hands for three seconds. The ST returned to the table, used R204's soiled napkin and tissues, which were still on the table, to wipe the surface of the table where R204 had been sitting, then picked up her electronic tablet and left the dining room. An interview with the ST on 01/04/22 at 12:12 p.m. revealed, "Basically, when I touch food, I try to wash my hands. I try to wash them for twenty seconds." When asked if she had performed hand hygiene appropriately while assisting R204, the ST shrugged and walked away. An interview with the director of nursing (DON), who also served as the facility's Infection Preventionist, on 01/07/22 at 9:02 a.m. revealed	F 880	reduce monitoring to three times weekly for four weeks, twice weekly for four weeks, then weekly until compliance is achieved. Results of audits will be forwarded to the facility Quality Council for Performance Improvement for review and recommendations.	

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F 880	Continued From page 47 the observation of the ST during the meal on 01/04/22, "Does not meet my standards in any way." An interview with the administrator on 01/07/22 at 10:45 a.m. revealed, "I am a nurse as well as an Administrator. What you saw is not acceptable."	F 880		

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	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/06/2022. At the time of this survey, Madonna Towers of Rochester was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/26/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Madonna Towers of Rochester is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V(111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building are a	K 000		

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K 000	Continued From page 2 Type II(111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a V (111) building. This will be surveyed as one building under LSC 2012. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 64beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		2/2/22

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K 321	Continued From page 3 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1.1 and NFPA 80 (2010 edition), Fire Doors and Other Opening Protectives, section 5.2.5.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/06/2022 at 11:00 AM, it was revealed by observation that during walk-through of the facility, a 20 minute rated door for the clean linen room has three 1/2" small holes located in the door for a locking device that was removed located in (A) hallway. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321- Enclosure 1. The doors that were in question have been corrected or are being corrected for closing. As well as the laundry door that had a few holes in it. 2. The doors will be checked on a weekly recurring basis for compliance. 3. Keeping the documentation updated in the fire book. 4. Paul Mattson EVS is responsible or designee	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		2/2/22

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MADONNA TOWERS OF ROCHESTER INC	**4001 19TH AVENUE NORTHWEST** **ROCHESTER, MN 55901**

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K 353	Continued From page 4 inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5 and NFPA 25 (2011 edition), Standard for the Inpsection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/06/2022 at 10:00 AM, it was revealed by observation during a walk-through of the facility that there was dust found on two of the fire sprinkler heads located in the kitchen area close to an air diffuser. An interview with Facility Maintenance Director verified this deficienct finding at the time of	K 353	There is attached documents for the fire sprinkler system. Both dry and the wet system. So that should have not been an issue. As far as the dust found on the sprinkler heads. 1. This will be added to the weekly cleaning checklist. 2. Keeping proper documentation on this issue. 3. Checking weekly sign off sheets. As well as visual inspections. 4. Gwen Fredrick Culinary Director and Paul Mattson EVS.	

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	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2022**

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MADONNA TOWERS OF ROCHESTER INC	**4001 19TH AVENUE NORTHWEST** **ROCHESTER, MN 55901**

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K 353	Continued From page 5 discovery.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/06/2022 at 09:15 AM, it was revealed by a review of available documentation that no fire drills were conducted for the 3rd quarter, 1st shift, and 3rd shift, and for the 4th quarter-2nd shift and 3rd shift of the calendar year. An interview with the Facility Maintenance Director verified this deficienct finding at the time of discovery.	K 712	There is an attached document for the fire drills. The 3rd Quarter 3rd shift was done. Please see the document. 1. To make sure that all fire drills get done as they are required. 2. To make sure that the proper staff members are trained and can run the drills. 3. Keep proper paper work up to date and make sure that they are current. 4. Paul Mattson EVS	2/2/22
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		2/2/22

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K 918	Continued From page 6 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility	K 918	The generator did have issues waiting for the proper parts to arrive. But during this	

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K 918	Continued From page 7 failed to maintain, test, and inspect the essential electric system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.1.1.6.1 and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, section 8.3.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/06/2022 at 11:30 AM, it was revealed by a review of the available documentation that the facility failed to maintain and run the generator under load monthly. The generator would only perform at 20 percent capacity due to mechanical issues. An interview with the Facility Maintenance Director verified| this deficient finding at the time of discovery.	K 918	time. It was confirmed that all life safety were covered. The generator has been repaired and we will be doing a load test on it. 2. Trained staff will do the weekly and monthly testing. The testing will consist of load testing and no-load testing as required. 3. To keep the records up to date and make sure that the proper testing is being down. 4. Paul Mattson EVS	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2022

Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: NH0D11

Dear Administrator:

The above facility was surveyed on January 4, 2022 through January 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00419	A. BUILDING: _____ B. WING _____	01/07/2022

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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 1/4/22 through 1/7/22, a licensing 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 and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 surveyors 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff monitored edema and reported indicators of increased edema to the physician for 2 of 3 residents (R108 and R114) reviewed for edema. R108 experienced actual harmed when the facility failed to monitor his edema, failed to notify the physician of a six-pound weight gain in two days, applied compression stockings without a physician's order, and R108 developed two open wounds to his right lower extremity with related pain. In addition, based on observations, interviews and record review, facility failed to clearly communicate and implement fall	2 830	Corrected	2/2/22

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2 830	Continued From page 3 prevention interventions for 2 of 2 residents (R204 and R45) who had recently fallen in the facility. Findings include: R108's Face Sheet identified he was admitted to the facility on 12/28/21 with diagnoses including, mild chronic kidney disease, sepsis due to streptococcus, edema, and congestive heart failure (CHF). R108's Observation Detail List Report dated 12/28/21, indicated he had no open areas on his skin at the time of his admission to the facility, and had, "2 + pitting edema" (a build-up of excess fluid in the body to the point an indentation remains for up to 15 seconds after pressure is applied) to his lower extremities. R108's electronic medical record (EMR) revealed he had not had a Minimum Data Set (MDS) assessment completed at the time of survey. R108's Order History included, an order for daily weights for three days after admission beginning 12/29/21, and an order for daily weights beginning 1/3/22. Further review of R108's physician's orders revealed no orders for monitoring his edema, or any treatments to managing his edema. R108's care plan, included, "Resident with CHF, potential for alteration in vital signs," beginning 12/28/21. The approaches included, "Monitor for increased edema and significant weight changes and report to NP/PA/MD [Nurse Practitioner/Physician's Assistant/Physician] if occurs." "Protect resident from injury/trauma," and "weights as ordered," beginning on 12/28/21.	2 830		

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2 830	Continued From page 4 The care plan did not specify what constituted a significant weight change. R108's Care Guide for Unit B, where R108 resided and provided by the facility on 1/5/22, revealed R108 was, "at risk" for skin impairment, with no actual impairment. Further review of the Care Guide revealed no mention of R108's edema or location of his edema, or the use of compression stockings. R108's weights, identified he weighed 210.3 pounds on 12/29/21, 213.7 pounds on 12/20/21 (a gain of 3.4 pounds in one day), and 216 pounds on 12/31/21 (a gain of 2.3 pounds since the previous day and 5.7 pounds in 48 hours). Further review of R108's weights revealed no further weights were taken prior to 1/4/22 when his weight was 217 pounds. R108's nursing progress notes, dated 1/2/22, at 5:23 a.m. included, "Resident c/o [complained of] left leg pain during the night. Ted [compression] stockings were removed from both legs as they had rolled partially down each leg and the elastic was constricting each leg leaving grooves and causing the fluid to be trapped below the elastic. Both legs and feet have +2 pitting edema." Further review did not reveal whether the resident had an order for compression stockings, or if the physician was notified of the pitting edema. R108's progress notes dated 1/3/22, at 3:36 a.m. included, "Nurse was assisting resident back to bed during night when resident requested lotion be applied to lower extremities. Nurse then discovered skin breakdown and blistering/weeping of right lower leg. One wound and one major blister with other smaller blisters surrounding, drainage scant and from blister	2 830		

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2 830	Continued From page 5	2 830		

which is mostly intact. Foam dressings applied to these areas. Resident has compression stockings from home he has been wearing while at facility, he does not have current orders for compression stockings or wraps at facility."

R108's Nurse Practitioner progress notes dated 1/3/22, included, "2 blisters on the right lateral lower extremity that have burst under draining clear fluid now." The note did not specify what the blisters burst "under."

R108's general orders dated 1/3/22, included, once daily dressing changes to wo open areas on his right lower extremity.

R108's progress note dated 1/5/22, included, "Received orders for compression wraps to BLE [bilateral lower extremities] and foam dressings to open areas to RLE [right lower extremity]. Larger open blister area on right shin measured today 5 cm [centimeters] x [by] 2.5 cm, smaller open blister area next to it measures 3 cm x 2 cm."

R108's Physician progress note for R108 dated 1/5/22, included the physician was not informed of R108's weights on 12/29/21, 12/30/21, or 12/31/21. Further review revealed, "Bilateral lower extremity edema up to the knee level. He was weeping from the right lower extremity with 1 new blister anterior . . . on the right lower extremity. He has others that have burst . . . he does have bilateral lower extremity edema and his weights, although variable over the past 48 hours are certainly up - I suspect most of the weight is in his LEs [lower extremities]. It is possible he is up about 10 lb [pounds] post hospitalization . . . It is possible he will need IV diuresis if this weight trend continues . . . We will need to go to twice daily dressing changes, or more frequently if

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2 830	Continued From page 6 needed to the right lower extremity to control the edema soakage . . ." When interviewed on 1/4/22, at 2:07 p.m. R108 stated he had, "some blisters or something" on the back of his right leg, which he stated were new within the past two days and causing him some discomfort. During interview and observation with R108 in his room on 1/5/22, at 4:46 p.m. revealed R108 sitting in his wheelchair. His lower extremities were visibly swollen and loosely wrapped with a compression bandage. Compression stockings were in the resident's room, draped over the arm rest of a recliner in his room. The resident pointed at the stockings and stated, "I don't wear those. I don't know where they came from, but they hurt. They're garbage as far as I'm concerned, and you can take them with you." When interviewed on 1/5/22, at 5:33 p.m. nursing assistant (NA)-F stated, she was assigned to care for R108 that shift. NA-F stated that she worked for a staffing agency, rather than the facility itself, so was not familiar with R108. NA-F stated that she would refer to her Care Guide for information on that resident. NA-F referred to the B Unit Care Guide and stated that R108 was, "at risk for skin problems but doesn't have any skin problems right now." NA-F stated the facility provided her with the Care Guide, which she carried with her and used as a reference when providing care, since she did not have access to resident care plans as an agency staff member. Review of the Care Guide revealed columns for resident room numbers and names, transfer status, devices such as dentures or glasses the resident used, toileting status, assistance needed for Activities of Daily Living	2 830		

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2 830	Continued From page 7 (ADL's). whether the residents were "Skin/Fall Risk," and "Important Preferences." When interviewed on 1/6/22, at 11:13 a.m. NA-E stated he had worked with R108 in the past, but was not aware of any edema or if he wore compression stockings. NA-E stated that as a facility employee he could access both the care plan in the EMR and the Care Guide used by agency staff, but those two documents did not typically match one another. When interviewed on 1/6/22, at 2:41 p.m. licensed practical nurse (LPN)-D stated R108 did not have any open areas to his skin prior to 1/3/22, at that time it was discovered he was wearing ted stockings without an order and had developed blisters. When interviewed on 1/6/22, at 4:18 p.m. R108's medical doctor (MD)-A stated, it was her expectation that any resident admitted to the facility with a diagnosis of CHF would be placed on a "CHF Protocol" which included both daily weights and skin assessments. The MD stated that daily weights were the facility's primary mode of monitoring CHF so long as they were taken before breakfast each day and using the same scale for accuracy. The MD stated that the facility had not reported R108's almost 6-pound weight gain in 48 hours between 12/29/21 and 12/31/21 to her office, which she would have expected as part of the "CHF Protocol." The MD stated that in R108's case he had been admitted from a different hospital than the facility was accustomed to working with, and she had been on vacation at the time the resident was admitted, so somehow the "CHF Protocol" did not get initiated. The MD stated that the facility should not have placed compression stockings on the resident without a	2 830		

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physician's order and that when she first examined R108 on 1/5/22, his edema was such that she would not have ordered compression stockings because he had, "significant edema, to the point of weeping," and, "there was too much edema to apply them safety without causing skin damage or discomfort." The MD stated that R108 would have been unable to don his own compression stockings given the amount of edema he had.

When interviewed on 1/7/22, at 8:19 a.m. the director of nursing (DON) stated, he was not sure how R108 came to have compression stockings in his room, or who had applied them on 1/2/22 or 1/3/22. The DON stated, the facility was using agency staff to cover many shifts during this time, so it was difficult to tell who had provided care for R108 on those nights. The DON stated he presumed family had brought the compression stockings from home, but the staff should not have placed the stockings on R108 unless it was a physician's order and/or the stockings were on R108's care plan. The DON was asked to provide the facility's policy for Edema Management, as well as the "CHF Protocol" referenced by R108's MD. At 10:11 a.m. the DON stated, "technically" agency staff did have access to the care plans in the EMR, but the facility provided the Care Guide as a shortcut so they could provide care with a limited amount of orientation to residents. The DON stated that he updated the Care Guides on a spreadsheet in his computer daily and distributed them to the nurse's stations.

When observed on 1/7/22, at 10:11 a.m. with family member (FM)-B, and LPN-D, FM-B stated R108 had used compression stockings at home in the past, but his edema became so much the stockings were too tight, for about 2 months prior

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to hospitalization and nursing home admission. FM-B had been wrapping his legs with compression bandages instead. FM-B stated she had not brought the stockings that were draped over a chair in his room, in for him.

R108's wound care progress note dated 1/7/22, at 11:41 a.m. included, "Continues to have 2+ pitting edema of BLE (bilateral lower extremities) from toes to mid shin." "Right lower anterior had one open area and two smaller areas." The measurements were right lower anterior 1.1 cm. x 1.0 cm x 1.0 cm. The Superior anterior shin wound measured 2.2 cm x 1.2 cm x 0.1 c.m. The lateral right lower leg, "does not appear to have one large wound but now has area with pin point area within it. Total area 5.0 cm x 3.0 c.m. with pinpoint weeping areas throughout."

When interviewed on 1/7/22, at 10:31 a.m. the administrator stated, it was his expectation that the facility would identify CHF as a diagnosis for a resident at the time of admission, and if orders for the "CHF Protocol" were not present, then the nurse would notify the physician. The administrator stated it was his expectation that staff would not apply compression stockings without a physician's order. The administrator was asked to provide copies of the facility's Edema Management Policy and CHF Protocol. The administrator deferred these requests to the DON. The Administrator stated it would be his preference that all staff accessed the care plan in the EMR rather than try to keep a second Care Guide document that had to be updated separately, and he would work with his leadership team to, "make it happen."

When interviewed on 1/7/22, at 12:41 p.m. the DON stated the facility did not have an edema

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2 830	Continued From page 10 management or CHF protocol. R114's Face Sheet, undated, identified an admission date of 12/22/21, and a diagnosis of CHF. R114 did not have an MDS assessment completed at the time of the survey. R114's Physician orders dated 12/23/21, included and order to weigh daily, before breakfast, use the same scale every day. The physician was to be notified for weight gain greater than 2.5 pounds in 48 hours, or 5 pounds over admission weight. Dry weight was noted to be 274 pounds. The physician was also to be notified if weight was over 280 pounds or under 268 pounds. R114's weights since admission were documented as: On 12/22/21, R114 weighed 280.8. On 12/23/21, R114 weighed 282.8 (2.8 pounds over 280, defined as a notification point in the physician's orders) On 12/24/21, R114 weighed 280.8. On 12/25/21, R114 weighed 280.0. On 12/26/21, R114 weighed 248.8 (no explanation for this weight being 31.2 pounds down from the previous days' weight) On 12/27/21, R114 weighed 285.6 (warranting physician notification for being over 280 pounds and a gain of greater than 2.5 pounds in 48 hours) On 12/28/21, R114 weighed 286.3. On 12/29/21, R114 weighed 285.6. Review of R114's EMR, did not contain documentation that R114's physician was notified of weight variances on 12/23/21, 12/26/21, 12/27/21, or 12/28/21. When interviewed on 1/7/22, at 9:07 a.m. the	2 830		

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2 830	Continued From page 11 DON stated, the physician should have been notified of R114's weight changes. At 1:26 p.m. the DON provided documentation R114's physician had been notified of weight changes on 12/22/21, 12/29/21 and 1/3/22. However, the physician had not been notified of the weight changes 12/23/21, 12/26/21, 12/27/21, or 12/28/21. R204's admission Minimum Data Set (MDS) dated 12/23/21, was completed upon return from hospitalization on 12/17/21. The MDS indicated R204 had moderately impaired cognition and required extensive assistance of two persons with bed mobility, and did not stand or walk at that time. R204's diagnosis list included a history of recent falls, a recent fracture of his right ischium (lower part of pelvic bone under buttock muscles), dementia, secondary parkinsonism (similar to Parkinson's disease with tremors, stiffness, slow and reduced movements), among many other co-morbidities. R204's electronic health record (EHR) care plan indicated a problem, start date 12/17,21, "resident at risk for falling R/T [related to] unspecified fracture of right ischium, Parkinson's dse [sic], weakness. The goal for this problem area dated 12/17/21, "resident will remain free from injury." The interventions listed included, "12/17/21 keep call light in reach at all times" and "12/17/21 PT/OT as ordered", "12/25/21 offer resident to lie down for a nap after meals", and an additional intervention was added 1/7/22, "W/C [wheelchair] next to bed while in bed." A problem dated 12/17/21 indicated, "I have a self-deficit with the following activities of daily living; bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder." Listed interventions included, "I require assist of 2 to	2 830		

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assist me with transfers with EZ stand," updated/changed on 1/7/21 to read, "I require assist of 1 with FWW [front wheel walker] for transfers." However, the care plan maintained the following two interventions listed separately, "12/17/21 I require assist of 2 to get my toileting needs addressed", and "12/17/21 Using assistive devices can help me better take care of my deficits. I use: EZ Stand [mechanical device to assist with standing] with A x2 [assist of two persons]."

A paper document, "care guide" updated on 1/6/22, indicated R204 transferred with the assist of one person and a FWW, but did not walk. The care guide indicated R204 was a fall risk, but did not provide any indication of safety interventions. The following statement was printed at the top of the guide: "Important Notice: Please do not rely solely on these Care Guides. Please refer to resident Care Plan or Profile for more accurate and up to date information. The Profile can be accessed from POC [point of care, a documentation site in the EHR primarily for nursing assistants] by clicking on "Resident Profile" in the upper right corner of POC."

An event report dated 12/12/21 indicated R204's call-light was on, but staff found him on the floor in his room sitting against the bed. He was sent to the emergency room for respiratory symptoms at that time. No further assessment of the events leading up to the fall or interventions related to the fall were found documented.

A Fall Risk Acuity, balance and functional limitation observations was completed for R204 on 12/17/21. The document indicated a score greater than ten represented a high risk for fall. R204 was assessed to have a score of 17. The

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section of the form for a, "fall risk summary-identify risk factors that may contribute to the resident fall risk, including medications and environmental risk factors," contained no documentation. The referrals listed that, "may be appropriate" were checked as OT (occupational therapy) and PT (physical therapy). In the section titled: Plan of Care, the following was documented: "indicate care plan action taken: continue current plan of care."

An event report dated 12/20/21 indicated R204 had an unwitnessed fall at 4:14 a.m.; was found by a nursing assistant responding to his call light but he was laying on the floor next to the bed. The immediate intervention chosen was, "rest," no additional interventions documented including after IDT review to aid in preventing this type of fall from happening again.

An event report dated 12/25/21 indicated R204 had an unwitnessed fall at 10:54 a.m. in his room, and he had said he was getting himself into bed. No immediate interventions were listed as having been implemented except to say he would continue to be monitored. He was noted to have been already participating in therapy services at that time.

An event report dated 1/2/22 indicated R204 had an unwitnessed fall in his room at 12:25 a.m. He was found on his bedroom floor. The immediate intervention was observation, and a note indicated "post fall monitoring in place along with interventions added to care plan." No additional interventions documented.

A progress note written in R204's EHR on 1/3/22, 1:14 p.m. included the following: "IDT f/u [follow up] fall on 12/12, 12/20, 12/25 & 1/2/21 [sic]: On

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2 830	Continued From page 14 12/12, resident fell around 2:50 am call light was on and was answered promptly. He was found by the nurse sitting on his bottom with his back resting against his bed. No injuries noted. On 12/20, at 4:15 am resident was found lying on his right side, on the floor next to the bed. Resident denied any pain. No obvious injuries were found. On 12/25, resident was on the floor, assessed for injuries. None noted. On 1/2/22, resident found laying on back upon bedroom floor around 12:25 am. Resident denied pain, VS WNL (vital signs within normal limits), and ROM (range of motion) per resident's baseline. Resident is at risk for falls d/t [due to] history of repeated falls, schizotypal disorders (a personality disorder that may include paranoia, odd or unusual thoughts), Parkinsonism & dementia with Lewy bodies (proteins in brain affecting memory and thought). Most recent BIMS {cognitive assessment] is 9 indicating moderate impairment. RCA (root cause analysis): impaired gait/balance and poor safety awareness. Interventions include: Resident being sent to ED for evaluation of underlying health conditions, fall mat at bed side, lie resident down after meals and observe frequently and place in supervised area when out of bed." On 1/05/22, 3:21 p.m. R204 was observed in bed in his room, only the foot of the bed was visible from the door. After entering, was observed to be positioned somewhat on his right side using pillows and a soft touch call light in bed. The bed was at a standard height and wheelchair located about six feet away, facing away from him. A bedside table was positioned next to the bed. R204 had a moist cough, kept his head extended backward and mouth open. He was not able to answer questions at that time. 1/06/22, 10:42 a.m. R204 was observed in his	2 830		

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2 830	Continued From page 15 room sitting up in w/c, not able to be seen from hall. During an interview on 1/6/22, 10:50 a.m. a nursing assistant (NA)-B stated staff would know how to care for the residents if they were familiar and experienced at the facility, and the way to learn was to follow other staff and learn from them. NA-B said there was a paper care guide available, but was not able to describe how to access the EHR care plan when asked despite the notice on the care guide. NA-B was observed to be documenting in the EHR POC system at the time. NA-B said she sometimes trained the new or contracted "pool" staff. On 1/6/22, 10:59 a.m. NA-A, a "pool" staff, described the "care plan" as a piece of paper that would describe how to transfer a resident, move them in bed and "all that type of thing." NA-A also said, "after a while you learn them [resident cares]." NA-A stated R204 required the assistance of two persons to transfer. NA-A said the "care plan" indicated R204 was a fall risk and reported the following interventions to prevent falls as she knew them, "well, we put him in bed, and make sure he is positioned right, put his head up because he has trouble swallowing and needs to sit up. And we have to watch him, like if he turns on his light to go to the bathroom, stay, don't leave him." During an interview 1/07/22, 7:15 a.m. a licensed practical nurse, (LPN)-A stated she usually worked the evening and night shift, and confirmed that R204 had had several falls during the night. LPN-A said there were paper sheets that were a guide for nursing assistants and the more experienced staff would help those who were new. LPN-A stated R204 was quite impulsive, did	2 830		

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not use his call light, and said to prevent falls, persons working on the night shift would tuck a pillow under his right side which would remind him not to get up without help, and they would place his call-light under it so his weight would turn on the call-light. LPN-A thought R204 would benefit from having a fall mat on his floor and had reported this, but said she had never heard back and was unsure how decisions were made in relation to fall prevention. She stated she knew pressure alarms were noisy, but thought it would help R204, and was unsure of why they were no longer used, and also stated, "I miss side rails." LPN-A did not update care plan interventions and confirmed her recommendations were not listed on the care plan or care guide.

On 1/07/22, 8:46 a.m. LPN-C stated their overall team would discuss care plan interventions, and the Interdisciplinary Team (IDT) would meet after fall incidents to decide on appropriate interventions, especially for safety which would vary depending on the resident. LPN-C was unsure if night staff were involved in this process, but night shift were to attend a meeting on a monthly basis where they would receive information about any care plan changes. LPN-C said, as a clinical manager, she was responsible to update the care plan for R204 and other residents on the same unit. LPN-C said R204 should not have a fall mat because he might get up unassisted now that he was actively transferring with the assist of one at all times, and walking with therapy. Instead, LPN-C said R204 should have his W/C at his bedside with the breaks locked in case he would attempt to get up; however, LPN-C confirmed the EHR care plan did not indicate this was the appropriate intervention, nor did the care guide. LPN-C said she was going to update the care plan immediately as it was

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incorrect. LPN-C stated nursing assistants should be following the paper care guide, and confirmed R204's care guide did not match the EHR. LPN-C said clinical managers were responsible to update the care guide as well as the care plan in the EHR.

On 1/07/22, 9:42 a.m. the director of nursing (DON) stated information for safety interventions related to falls would vary according to the resident, and the full IDT team met every Wednesday to discuss any issues, but the facility would rely on the entire team to give input. DON said a meeting was held each month and staff were to attend, but for the best continuity of care, the nurses on the floor should communicate directly with the clinical managers, but that nurses or clinical managers could update the care plan. Also, if the IDT made recommendations the clinical managers were expected to talk to the nurse working on the unit who were then to share with the rest of the staff. DON also stated an expectation for appropriate interventions to be added to the care plan as soon as possible, and the care guide to also be updated as soon as possible. DON stated ideally the care guide and care plan should be matching. DON said the care guides had been designed for contracted pool staff to use for easy reference, but he had an expectation for those permanently hired to use the EHR care plan for a more complete listing of cares.

A facility policy titled Comprehensive Assessments and Care Planning, not dated but with a copyright of 2017, was provided. The policy outlined the process of completing assessments and updating care plan using the guidelines for the standard MDS upon admission, readmission, quarterly or when there is a significant change.

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2 830	Continued From page 18 The policy indicated the Care Area Assessments (CAA) would be used to develop the comprehensive care plan, saying: "the facility will use the findings from the CAA process as a starting point for developing the resident's comprehensive plan of care. Note: the facility is responsible for addressing the needs and strength of the resident weather [sic] or not it is included in the CAA process." The policy did not provide information on how to maintain accuracy when changes occur between assessment periods, or how to maintain continuity between the EHR and the handwritten care guides. A facility policy titled Integrated Fall Management, not dated but with a copyright of "20xx", was provided. The policy indicated, "Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort." In addition, the policy indicated, "Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment." Review of the facility's undated, "Integrated Falls Management" policy revealed, " ... A Fall Risk Assessment is completed ... within 48 hours of admission to the facility ... Residents at risk for falls have an individualized resident centered care plan developed ... " R45's Face Sheet identified, he was admitted to the facility on 11/23/21 and re-admitted on 12/01/21 with diagnoses which included COVID-19, Congestive Heart Failure (CHF), chronic respiratory failure with hypoxia (lowered	2 830		

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2 830	Continued From page 19 concentration of oxygen in the blood), Type 2 diabetes mellitus, muscle wasting and atrophy, unsteadiness on his feet, and repeated falls. R45's Fall Risk assessment, dated 11/23/21, identified fall risk factors included neuromuscular and functional impairment such as decline in functional status, hypotension, or syncope; impaired balance; range of motion impairments in both of his upper extremities; and the use of anticoagulant, antihypertensive, diuretic, and narcotic medications. R45's care plan dated 11/23/21, included a problem area for fall risk, the only approach to prevent falls was to keep the call light in place. R45's progress notes dated 11/25/21, at 2:45 a.m. included he had been sent to the hospital for shortness of breath and chest pressure. R45's progress notes dated 12/1/21, at 12:00 p.m. identified he had returned from the hospital where he had been for fluid overload, COVID-19 infection, weakness needing a mechanical lift and to assist R45 out of wheel chair and into bed. R45 had muscle spasms and tingling in lower extremities. R45's medical record did not include a new fall risk assessment with his change of condition. R45's care plan had not been updated regarding increased need for assistance or fall interventions. R45's progress note dated 12/2/21, at 5:12 a.m. identified, R45's knees were buckling, had an unsteady gait and transfer needs were to be re-evaluated.	2 830		

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	00419	A. BUILDING: _____ B. WING _____	01/07/2022

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2 830	Continued From page 20 R45's Event Details report dated 12/2/21, at 12:57 p.m. identified, "Staff heard resident calling for help, and found him laying on the floor in the prone position." "Resident stated he was sitting on the side of the bed and fell forward." Immediate intervention was listed as: "he was encouraged to not sit at the side of the bed, which he agreed to do and demonstrated verbal understanding," and a work order put in for bed with grab bars and bariatric recliner. R45's care plan had a new fall prevention approach added on 12/2/21, "I have been encouraged to not sit on the edge of the bed." R45's admission MDS dated 12/7/21, identified cognitively intact need for extensive assistance of 2 for bed mobility and transfers, did not ambulate, was not stead and had experienced one fall with injury since admission. R45's care plan added the fall intervention on 12/9/21, of grab bars and bariatric recliner. R45's progress note dated 12/15/21, at 8:22 a.m. included, "Resident legs are bending, lifting, moving outside of the resident's control ... Therapy/nursing is concerned about potential spinal stenosis as the cause for the movements being observed. His arms are also weak." R45's progress note dated 12/21/21, at 2:22 p.m. identified the nurse practitioner wanted R45 seen at emergency department. Another progress note dated 12/22/21, at 1:19 a.m. identified R45 had been returned to the facility with no new orders. R45's progress note dated 12/29/21, at 3:51 a.m. included, "heard someone yelling 'help' down the hallway ... noticed resident on floor facing down	2 830		

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2 830	Continued From page 21 ... deep laceration to the left upper portion of his forehead with a moderate amount of blood on the floor and continuing to bleed ... Resident stated that he had a spasm and his trunk flew forward. Call light was not on but was within reach." Further review of this progress note revealed Emergency Medical Services (EMS) were summoned and the resident was sent to the ED for treatment of the laceration. R45's care plan had a new approach to prevent falls added on 12/31/21, of, "I have been encouraged to sleep in bed and not my [wheelchair]." During observation and interview with R45 on 1/4/22 at 9:29 a.m. R45 was sitting in wheelchair in his room with his overbed table pulled close to abdomen. R45 had a reddish colored scar on his left eyebrow, and a second upside down L-shaped scar extending from between his eyes above his nose, across his forehead to above his left eye just below his hairline. The L-shaped scar appeared to be from a laceration which had been sutured. R45 stated the scars were from falls he had in the facility. The resident stated that the first fall, which resulted in the scar on his eyebrow, had been because he became fatigued and fell forward while sitting on the edge of his bed, and the second had been when he had a spasm while sitting in the wheelchair and fell forward onto his face. R45 stated that after the second fall he was sent to the hospital for sutures. R45 stated he continued to experience spasms daily. R45 stated the facility had not implemented any measures to prevent further falls as far as he knew, but he had taken it upon himself to pull his wheeled overbed table snugly to his abdomen while he was sitting in his wheelchair as he believed that would prevent him from falling should he experience	2 830		

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2 830	Continued From page 22 another episode of fatigue or a "severe" muscle spasm. When interviewed on 1/5/22, at 5:40 p.m. NA-F stated she had been assigned to care for R45 since 6:00 a.m. NA-F worked for a staffing agency and was not familiar with R45's needs. She had a care guide provided by the facility and used that as a reference. Review of the "Care Guide" revealed columns for resident room numbers and names, transfer status, devices such as dentures or glasses the resident used, toileting status, assistance needed for Activities of Daily Living (ADL's). NA-F stated that because she worked for a staffing agency, and not the facility itself, she could not access individual resident care plans. NA-F consulted the Care Guide in her pocket, then stated that R45 was at risk for falls. When asked what that meant, NA-F stated that it either meant that she had to "check on him every 15 minutes or so" if he was confused or had to "respond quickly to his call light" if the resident was alert and oriented. NA-F stated that she was unable to tell which applied to R45 without looking at him. The surveyor accompanied NA-F to R45's room, where R45 was sitting in his wheelchair with his overbed table pulled snugly in front of his abdomen. NA-F stated R45 was alert and oriented so she did not have to check on him more frequently than every two hours but should respond quickly if the resident activated his call light. NA-F stated that there was "nothing special" she had to be aware of in terms of R45's safety or fall risk with him sitting in his wheelchair in his room. When interviewed on 1/5/22, at 5:45 p.m. R45 stated he had a recliner in his room, but was currently sitting in his wheelchair. R45 stated the facility had brought in the recliner at some point,	2 830		

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2 830	Continued From page 23	2 830		

which may have been after his first fall, but did not instruct him to use it as a preventive measure against further falls and, "It wouldn't work anyway. I can't lift the footrest." R45 stated the facility wanted him to sleep in his bed and not the recliner or the wheelchair, but he found that difficult because he liked his head elevated to make it easier to breathe. R45 stated sometimes he ended up sleeping in the recliner without the footrest up, which felt "a little more secure" than his wheelchair, but he was concerned another spasm could result in falling from the recliner unless the footrest was up. R45 stated staff typically checked on him "every couple of hours" unless he put his call light on, which would be fine "unless I have another spasm that causes me to fall." R45 stated it was his expectation that staff caring for him would be knowledgeable about his fall history and checking on him frequently to ensure his safety.

When interviewed on 1/6/22, at 11:16 a.m. NA-E stated he regularly cared for R45. NA-E stated that he was aware R45 had fallen in the past but did not consider him to be a current fall risk because "he's total assist with almost everything." NA-E stated there were no special precautions staff had to take to prevent falls for R45 and checking on him every two hours was sufficient.

When interviewed on 1/7/22, at 8:30 a.m. the director of nursing (DON) stated, he considered R45 a fall risk based on his history of falls in the facility. The DON stated that the location of R45's room, which was "right in the middle of the hall" resulted in increased supervision, and that staff were also encouraging frequent position changes and offering to lay R45 down. When asked about NA-F's lack of familiarity with R45's fall history or any precautions she should be aware of when

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2 830	Continued From page 24 caring for R45, the DON stated, "Well she's a pool [staffing agency] CNA [Certified Nursing Assistant], so I would not expect her to have the same depth of information that someone on our own staff would have." The DON stated R45's recliner should be used, "In the reclined position if he is taking a nap or resting," and R45 was using it that way as far as he knew. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit orders for residents with fluid imbalance and ensure they are clear, adequate and understandable. DON or designee could ensure all nursing staff receive education on fluid balance issues, edema monitoring and appropriate intervention. Audits could be done to ensure compliance of proper daily weights, edema monitoring, documentation of fluid intake and proper reporting as applicable. The DON or designee could design a plan to make sure resident care guides match the comprehensive care plan; additionally, DON or designee could provide on-going training to staff on how to access the electronic record for the care plan, and the importance of accuracy between the two documents. The DON or designee could do audits to ensure care plans and care guides are updated on a regular basis, they match, and all staff are following resident care plan interventions as listed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered	2 940		2/2/22

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2 940	Continued From page 25 and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, record review, and policy review the facility failed to ensure the prescribed therapeutic diet was followed for 2 of 2 residents (R3 and R204) reviewed for therapeutic diets; resulting in the potential for choking, aspiration and weight loss to occur. Findings include: R3's Face Sheet, undated, indicated an admission date in August 2019 and readmission 11/4/21. Diagnoses included, diabetes, dysphagia (difficulty swallowing), depression and chronic pain. R3's quarterly Minimum Data Set (MDS) dated 12/15/21, identified R3 was cognitively intact and did not have signs or symptoms of a swallowing disorder. R3's physician orders directed staff to provide a pureed diet and was dated 11/10/21. When interviewed on 1/4/22, at 10:30 a.m. R3 stated, "I am supposed to be on a pureed diet, but lately they have been sending me regular food." R3 stated she was on a pureed diet due to dysphagia difficulties. R3 was evaluated by the speech language pathologist (SLP) on 11/09/21 and determination was made for the pureed diet. The SLP made recommendation to R3's physician who agreed and implemented the order on 11/10/21. During an observation on 1/4/22, at 11:50 a.m. of	2 940	corrected	

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2 940	Continued From page 26 R3's lunch meal, R3 received chicken and rice that appeared to be a ground texture and not pureed along with three pieces of whole cauliflower florets. R3 stated "I tried to eat the chicken and rice and it didn't go down very easy." The dessert was a blueberry bar (cake like texture) that R3 ate in this surveyor's presence and stated it went down fine. Liquids were served regular consistency, as per the current diet order. The meal ticket on R3's tray was noted with pureed diet circled. During an observation on 1/5/22 at 11:30 a.m. R3's lunch meal was observed delivered to her room at 11:25 a.m.. R3 was not in her room at the time. Observation of the lunch meal revealed a regular texture full taco salad with whole tortilla chips. No pureed items were noted on her tray. Tray ticket was observed and noted to have "pureed" diet circled. During an interview on 1/5/22, at 3:30 p.m., R3 stated she was unable to eat her entire taco salad. R3 stated she was unable to eat the lettuce, chips, and some of the meat due to the consistency. During an observation on 1/5/22 at 4:50 p.m., R3 had her dinner meal tray which was not pureed. R3 stated "I had mashed potatoes and cream of mushroom soup, but I couldn't eat the Spanish rice dish." During an interview on 1/6/22, at 3:30 p.m. with the culinary services director (CSD), registered dietician (RD), and director of nursing (DON); the CSD stated R3 frequently would go into the kitchen and "yell at the kitchen staff that she wants regular food and not pureed." However, both the CSD and RD stated those interactions	2 940		

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2 940	Continued From page 27 were not documented in R3's chart and the CSD confirmed the current diet order for R3 was a pureed diet and that would be expected to be delivered to her. The RD stated she was not aware that R3 did not want a pureed diet and had not spoken with her to discuss any potential changes to her current diet. The DON stated that nursing should be documenting refusals for the pureed diet and communicating with the kitchen staff, CSD or RD for a review, or changes, to her diet. R204's admission MDS dated 12/23/21, completed as a readmission assessment after hospitalization on 12/17/21, R204 had moderately impaired cognition, required the extensive assistance of one person for eating. R204's diagnosis list included dementia, secondary Parkinsonism (similar to Parkinson's disease with tremors, stiffness, slow and reduced movements, poor coordination) and dysphagia (difficulty swallowing foods and liquids) along with many other co-morbidities. R204's care plan indicated a problem, start date 1/5/22, "I have ineffective breathing patterns related to: aspiration, as evidenced by : Dx [diagnosis] of dysphagia, coughing, pureed diet with nectar thick liquids]. Additionally, the care plan also contained a problem dated 12/10/21, "I have an alteration in nutrition/hydration status r/t to [sic] dx of dysphagia, hx [history] of aspiration events and need for mechanically altered diet order and assistance at meals." The goal stated: "provide diet as ordered (pureed texture with honey-thickened liquids 12/10/21) and recommended in accordance with ST [speech therapy]. On 12/10/21 the following intervention was added, "provide nutritional supplement: 8 oz Ensure clear (honey-thickened)."	2 940		

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2 940	Continued From page 28 A paper document "care guide" updated on 1/6/22 indicated that R204 had dysphagia and required a pureed diet with nectar thickened liquids. According to R204's physician orders with a start date of 12/27/21, diet: dysphagia (pureed) Liquids: nectar consistency. On 1/05/22, 3:21 p.m. R204 was observed in bed in his room, only the foot of the bed was visible from the door. After entering, was observed to be positioned somewhat on his right side using pillows and a soft touch call light in bed. R204 had a moist cough, kept his head extended backward and mouth open. He was not able to answer questions at that time. 1/06/22, 10:42 a.m. R204 was observed in his room sitting up in w/c, not able to be seen from hall; had half glass of thickened orange juice without a lid or straw and a glass of water with lid, but no straw sitting next to him on a bedside table. A boxed serving of Ensure Clear was also sitting on the table, the contents could not be observed, there was no indication if it was thickened and no straw was present. During an interview on 1/6/22, 10:50 a.m. a nursing assistant (NA)-B stated staff would know how to care for the residents if they were familiar and experienced at the facility, and the way to learn was to follow other staff and learn from them. NA-B said there was a paper care guide available, but was not able to describe how to access the electronic care plan. On 1/6/22, 10:59 a.m. NA-A, said the care guide provided interventions for resident care. NA-A	2 940		

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2 940	Continued From page 29	2 940		

said it was important for R204 to be "positioned right, put his head up because he has trouble swallowing and needs to sit up".

At 1/06/22 11:04 a.m. NA-A was observed to enter R204's room where he was sitting in his wheel chair. NA-A told R204 it was time for his meal, but he pointed at the fluids sitting nearby on an overbed table. NA-A asked if he wanted his Ensure and R204 nodded. The Ensure Clear was observed in its original boxed container. NA-A placed a straw into the container and gave R204 a drink, and then took him to the dining area.

During an interview on 1/06/22, 11:08 a.m. a registered nurse (RN)-B looked at the container of Ensure Clear in R204's room and confirmed the container did not have any information related to its consistency. RN-B said, "well, it's definitely thicker than water, but I guess I don't know [consistency]." RN-B said she thought perhaps the people in the kitchen would know if the product was thickened. At that time NA-A re-entered the room and said, "he's taking it, he's taking it."

At 1/06/22, 11:12 a.m. a dietary aid (DA)-A stated Ensure Clear was not a pre-thickened product. Immediately after, the registered dietician (RD) stated an expectation for whomever was taking the product to a resident to use a thickener provided in the dining area as needed, following the written directions, before taking it to a resident's room.

At 1/06/22, 11:15 a.m. in R204's room, RN-B retrieved the Ensure Clear left in the room and poured approximately two ml into a clear plastic cup and compared the solution to R204's thickened juice and thickened water sitting on his

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2 940	Continued From page 30	2 940		

bedside table. RN-B confirmed the Ensure Clear appeared to be more liquid in nature than the other two beverages, and stated it did not appear to be "nectar thick."

During an interview 1/06/22, 1:51 p.m. the RD said nursing assistants or dietary could thicken liquids, stating it was the responsibility of nursing staff to thicken any liquid to match the orders if they were the one bringing it to a resident who requires thickened liquids. RD was not able to say how a person would know R204's Ensure Clear had already been thickened if they found it in the room. RD stated a concern in providing non-thickened liquids to R204 as it might make his dysphagia "act up." The Culinary Services Director who had been listening stated, "that's a problem. We should do something. It should be poured into a glass if you don't know."

On 1/06/22, 2:41 p.m. the DON stated it was the responsibility of the culinary services to obtain the correct product for persons who require thickened liquids, and they were the ones who would know who had the ability and training to prepare it. DON stated nursing assistants should know that thickened liquids are required by looking at the care plan or care guide, but the liquid should come in the proper state from the kitchen. DON said a nurse might thicken liquids if they were able to read and understand the package instructions. DON confirmed that only the person who had prepared the Ensure Clear for R204 would be able to know if it had been thickened as it was not visible through the container.

On 1/07/22, 9:57 a.m. the DON stated a new order for Ensure Plus had been received for R204. DON then said, the only persons who could mix thickened liquids were dietary staff, and

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2 940	Continued From page 31 not nursing staff, and this was not a new policy. A facility policy titled Thickened Liquids, not dated but with a copyright of 2012, indicated "residents receive thickened liquids per a physician's order which specifically states the consistency of the thickened liquids. It is the responsibility of all staff to ensure that the resident receives all liquids in the appropriate consistency to prevent aspiration while promoting adequate hydration." The consistencies matching those used at the facility were described as: nectar thick-consistency of thin milkshake or eggnog, honey-consistency of honey at room temperature or a thick milkshake or pudding thick-consistency of pudding and does not run off a spoon. The responsibility of thickening liquid was described as "culinary services will be responsible for providing thickened liquids for meals and nourishments and commercially prepared products that are used for medication administration. In addition, the policy indicated the need for thickened liquids should be documented on the resident care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or registered dietician (RD) could provide training to all existing dietary and nursing staff about the importance of providing fluids in the appropriate thickness or consistency, providing information on the potential risks to a resident who may not be able to consume fluids of a thin consistency. Further education could be provided on who in the facility may alter the consistency of fluids for a resident; how to check if the appropriate consistency is being offered and who to report to if there are any questions regarding the appropriate thickness of fluids offered. DON or RD could do audits to	2 940		

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2 940	Continued From page 32 ensure that only the appropriate persons are altering the consistency of fluids, and that staff understand and offer the ordered and appropriate fluids as ordered. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 940		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure proper hand hygiene while caring for 1 of 16 residents observed for personal cares. Findings include: Review of the facility's "Hand Hygiene" policy, dated June 2017, revealed, " ... Times to Perform Hand Hygiene are, but not limited to ... Before and after direct resident contact ... Before and after assisting a resident with meals - wash hands with soap and water ... After contact with a resident's mucous membranes and body fluids or excretions ... " Review of R204's "Face Sheet," located under the "Face Sheet" tab of his electronic medical	21385	Corrected	2/2/22

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record (EMR), revealed he had been most recently admitted to the facility on 12/17/21 with diagnoses which included dysphagia, Lewy body dementia, need for assistance with personal care, and need for continuous supervision. Further review of R204's EMR revealed no Minimum Data Set (MDS) assessment had been completed at the time of survey.

Observation of R204 on 01/04/22 between 11:32 AM and 12:12 pm. R204 was sitting in his wheelchair at a table in the dining room and was approached by the Speech Therapist (ST). The ST did not perform hand hygiene before approaching the resident. The ST was carrying an electronic tablet, which she placed on the table near R204, then crossed the room to the serve-out kitchen where she obtained two bowls of food. The ST had not performed hand hygiene and was not wearing gloves. The ST grasped each bowl by placing her thumb and index finger on each side of the rim, with her thumb inside the bowl, to carry them across the room to R204. The ST used R204's spoon to stir the contents of one of the bowls, then placed a spoonful of food into his mouth. The resident began coughing and she picked up his cloth napkin which she used with her bare hand to cover his mouth. When R204 was no longer coughing, she left the table and, without performing hand hygiene, went into the ante area of the serve-out kitchen where she obtained several small cartons of beverages. The ST placed all but one of the cartons in a reach-in refrigerator in the serve-out kitchen then returned to R204 with the remaining carton. R204 began to cough, and the ST picked up his cloth napkin to cover his mouth. After assisting the resident with a few bites from his bowl, the ST obtained two tissues from a dispenser on the table, handed them to R204 and instructed him to blow his

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nose. R204 blew his nose as instructed then placed the used tissues on the table next to his plate. The ST continued to assist R204 in this manner throughout the meal. The ST was touching her face to push up her glasses throughout the observation. At 12:03 PM, R204 began to cough more persistently and with more intensity. The ST responded by using first her bare hands, then his cloth napkin, then the soiled tissues with which R204 had blown his nose to cover his mouth. While other staff assisted R204 from the table, the ST went to the hand washing sink at the edge of the dining room where she washed her hands for three seconds. The ST returned to the table, used R204's soiled napkin and tissues, which were still on the table, to wipe the surface of the table where R204 had been sitting, then picked up her electronic tablet and left the dining room.

An interview with the ST on 01/04/22 at 12:12 p.m. revealed, "Basically, when I touch food, I try to wash my hands. I try to wash them for twenty seconds." When asked if she had performed hand hygiene appropriately while assisting R204, the ST shrugged and walked away.

An interview with the director of nursing (DON), who also served as the facility's Infection Preventionist, on 01/07/22 at 9:02 a.m. revealed the observation of the ST during the meal on 01/04/22, "Does not meet my standards in any way."

An interview with the administrator on 01/07/22 at 10:45 a.m. revealed, "I am a nurse as well as an Administrator. What you saw is not acceptable."

SUGGESTED METHOD OF CORRECTION:

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21385	Continued From page 35 The director of nursing (DON) or designee could retrain staff, including therapy staff, on the importance of hand hygiene on, during and after feeding a resident, and maintaining a clean environment while assisting residents to eat. Audits could be done to ensure that hand hygiene and other infection control practices are routinely followed in the dining area. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21385		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete an assessment and education for self-administration of medications for 1 of 1 resident (R3) reviewed for self-administration of medications from a total sample of 16 residents, resulting in the potential for medication errors related to the inappropriate self-administration of medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/15/21, identified cognitively intact and required supervisor for most activities of daily living. R3's diagnoses included, diabetes, rheumatoid	21565	Corrected	2/2/22

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21565	Continued From page 36 arthritis, depression and chronic pain syndrome. During a room observation and interview on 1/4/22, at 10:30 a.m. R3 had multiple prescription medications in her room. R3 verbalized the medications were current medications that she gave them to herself. The medications included eye drops, inhalers, and a topical antifungal cream. R3 stated she performed her own blood sugar checks during the day, approximately four to six times a day, and the supplies were observed in a plastic container on her dresser. R3 stated she informed the nurse when she completed the blood sugar check, and the nurse administered her insulin based on that. R3 further stated, and showed this surveyor, her nebulized mist treatment (NMT) set up in the bottom drawer of her dresser, with four NMT ampules (not labeled) and stated she does her NMT's, "Whenever I feel the need to do them," and that she cleaned the medication cup and mouthpiece on her own when she was done. During an interview on 1/5/22, at 3:45 p.m. and review of the medications in R3's room with R3 present, 16 medications were reviewed with R3. 1. Antihistamine eye drops read one each eye twice a day. R3 stated, "I do myself." 2. Nasal spray one spray each nostril twice a day. R3 stated, "I do myself." 3. Flonase nasal spray two sprays each nostril daily. R3 stated, "I do myself." 4. Ciprodex ear drops two drops right ear for seven days for right ear infection prescribed 6/7/21. R3 stated "I am not using that any longer. I just haven't given it back to the nurse." 5. Two Ventolin (respiratory medication) inhalers (INH) two puffs twice a day. R3 stated "I use the one that shoots out better." However she was	21565		

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unable to state what INH was the preferred one.
6. Diclofenac (mild analgesic) topical cream for mild arthritic pain, use as needed.
7. Lidocaine gel three times a day as needed for moderate/severe arthritis. R3 stated she used the gel for pain if the Diclofenac cream did not work.
8. Two tubes of Triamcinolone Acetonide (antifungal cream) 0.025% cream for, "a rash I had a while ago," medication was prescribed 11/5/21 and resident stated, "I no longer use."
9. Artificial Tears one drop each eye three times as needed prescribed 7/6/21 and resident stated, "I no longer use."
10. Glucose tabs eight tabs in a container of 10 total, resident stated, "it's been a while since I used any as I have others in my purse."
11. DuoNebs (combination respiratory medication of Atrovent and Albuterol) ampules four, unlabeled in bottom dresser drawer. R3 stated, "it's been a while since I've had to use my breathing machine," and when asked if R3 knew what medication they were, she stated, "no I don't know what it is." R3 also stated the nurse knew she used it when, "they see the machine on my nightstand." R3 further stated the facility had not provided any education to her regarding how to utilize the DuoNeb's, give her eye drops or observe her when doing her own blood sugar checks.

R3's EMR for the January 2022 physician orders, under the, Orders tab revealed orders dated 11/5/21, which included, "resident is ok to self-administer Albuterol, Advair, DuoNebs (all respiratory medications) and Flonase (nasal spray) after set-up." No other specific orders were noted for R3 to complete her blood sugar checks, eye and ear drops or creams.

R3's EMR under the Miscellaneous tab revealed

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a Self-Administration of Medications assessment, completed on 11/4/21, when R3 was readmitted after a hospitalization. The assessment from 11/4/21, covered her respiratory and nasal medications only, and did not include the eye drops, creams, or completing her own blood sugar checks.

During an interview on 1/6/22, at 10:40 a.m. Registered Nurse (RN)-B stated, the first step to determine if a resident can complete the medication pass they are requesting was to complete a Self-Administration skills observation form. RN-B stated she was aware that R3 kept creams, eye drops, and inhalers in her room, but had not personally gone over them with the resident to see what medications were current and/or expired. RN-B stated, she typically asked R3 if she had completed the medications for documentation purposes. RN-B stated she was unaware how often the medications were reviewed/looked at for current doses/not expired and stated she did not routinely observe the resident perform her blood sugar checks, complete her eye drops, or inhaler.

During an interview on 1/6/22, at 11:30 a.m. RN-A stated that she completed the Self-Administration of Medications assessment, dated 11/4/21, based on the history of R3 and as part of the re-admission process. RN-A was only able to speak to the respiratory and nasal medications and not the creams, eye drops, or ear drops. RN-A did state that R3 was able to self-administer the respiratory and nasal medications, "after set up by the nurse or trained medication aide [TMA]." RN-A also stated, "after set up" meant the nurse or TMA brought the resident her medication and then resident was allowed to do on her own, but not for the medications to be left

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21565	Continued From page 39 in her room. During an interview on 1/6/22, at 1:30 p.m. with the director of nursing (DON) and licensed practical nurse (LPN)-D, the DON confirmed R3 was able to self-administer her respiratory and nasal medications after set-up by the nurse or TMA, but not to have the medications left in the room. The DON also stated he was not aware until, 1/6/22, that R3 had sixteen medications in her room. The DON stated the facility currently did not have a system in place for review of appropriateness for a resident to continue with self-administration of medications or checking the medications in their room. During an interview on 1/6/22 at 4:00 p.m. with R3's medical doctor (MD), she stated she was aware, and agreed, with R3 self-administrating her respiratory and nasal medications. The MD also stated she would expect the facility to notify her if there was any significant change in R3's condition that would that affect R3's ability to continue to self-administer medications. The MD further stated, regarding medications, she would expect the facility would conduct a review of any medications in R3's room to assure that medications are current, not expired or duplicates. The MD further stated the resident may complete her own blood sugar checks, and R3 had conducted a fingerstick for her in December 2021, in which the MD was able to determine her continued ability to do so. The MD stated she was aware R3 had an order for completing her own blood sugar checks but was not aware in the facility EMR that the order, originally dated 6/30/20, had not been reinstated when the resident was re-admitted in December 2021. The MD stated in her EMR system the order showed as active and stated it was an	21565		

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21565	Continued From page 40 oversight of the facility to not reinstate the order as she continues to feel R3 was capable to complete her own finger sticks. Review of the facility's policy titled, "Self-Administration of Medications," initiated on February 2019 revealed, " ...Residents will approach nurse at the time they are required, and the nurse will transfer the unopened medication to the resident to self-administer ..." and " ...Reevaluation of the ability to self-administer will be done according to the interdisciplinary team (IDT) Observation Guide ..." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could educate nursing staff on the process for assessments, physician orders and expectations for residents to be able to safely self administer medications. The DON or designee could initiate audits, including room audits to assure medications are not left in rooms of persons not yet evaluated as competent to self-administer medications are not doing so. Additionally, new residents and their support persons could be educated upon admission and as needed about the assessment process for safe self-administration medication of medications to assure medications are not available to residents in their rooms until deemed safe to do so. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils	21942		2/2/22

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21942	Continued From page 41 Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interviews and record reviews, facility failed to make regular attempts at the formation of a family counsel. In addition, based on Resident Council interview, policy review, and review of the Resident Council meeting minutes, it was determined the facility failed to follow up on concerns brought forth by the Resident Council, for five residents (R 3, R11, R15, R17, and R30) who regularly attended council meetings out of a total census of 54. The failure created the potential that residents would not have care needs met or experience weight loss when the facility did not respond to concerns with nursing staffing levels and meal service. Findings include: On 1/06/22, 4:04 p.m. the facility social worker (SW) stated the facility did not have a family counsel, and further stated, "to be honest, we didn't send anything out this year. We did the year before I think." No further information was provided at that interview.	21942	Corrected	

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21942	Continued From page 42 A document without title, but with the date of March 10, 2020 was provided. The document contained the greeting:" Dear Family and Friends, are you interested in being a part of Family Council and would you like to learn more about Family council?" This document provided information about the purpose of family council and a survey about goals and interests. On 1/7/22, 12:53 p.m. the facility Administrator stated he felt face to face communication between departments in the facility was important and thus has a meeting for departments to talk, and a monthly meeting for staff; however, he was unable to address why a family counsel had not been established or why no attempt had been made in the last year. Administrator stated and expectation that efforts would be made and said, "I will have to talk with the SW." No further information was received. Review of the facility's undated Resident Council policy revealed, "the facility listens to . . . and acts upon the concerns . . . of the residents . . . The facility demonstrates follow-through on written requests/concerns voiced by the Resident Council." During an interview with the Resident Council on 1/6/22, at 1:11 p.m., all five residents in attendance (R3, R11, R15, R17, and R30) stated that they regularly attended Resident Council in the facility and had been complaining, "for months," about delayed call light response times and lack of staffing. The residents complained that the facility relied heavily on staff from nursing staffing agencies; but the agency staff did not seem to know the resident's specific care needs. All five residents further complained that the facility did not always honor their food	21942		

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preferences and requests or would tell residents they were out of requested food items. The residents reported these concerns were noted in the Resident Council minutes each month, but they did not receive information as to how the facility planned to address the concerns and their concerns had not been resolved.

Review of the Resident Council Meeting minutes for 7/6/21, 8/3/21, 9/7/21, 10/5/21, 11/2/21, 12/7/21, and 1/4/22, provided by the facility, revealed the Resident Council voiced concerns with food service at each meeting except the meeting on 10/5/21; and concerns with staffing levels all months except 8/3/21. Further review of the Resident Council Meeting minutes revealed no feedback to the residents as to how the facility planned to resolve the concerns, or resident satisfaction with the outcomes.

When interviewed on 1/7/22, at 10:31 a.m. the administrator stated, it was his expectation that when the Resident Council brought forth a concern, the Social Worker (SW) would bring it to the attention of the facility leadership team, the leadership team would come up with an action plan to address the concerns, and the SW would keep the residents informed of the progress towards resolution. The administrator stated, he was aware of the residents' concerns, and that the SW would have documentation of the facility's feedback to the residents. "I know we have a communication problem with the residents, and we need to do a better job with that."

When interviewed on 1/7/22, at 11:18 a.m. the SW stated, she aware of the ongoing concerns of the Resident Council but had not documented the plans to resolve those concerns or communicated them with the residents. When informed that the

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	00419	A. BUILDING: _____ B. WING _____	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

(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
21942	Continued From page 44 residents in attendance felt the facility was not resolving their concerns, the SW stated, "Well that's a lie, but whatever." SUGGESTED METHOD OF CORRECTION: Facility Administrator or social service designee could ensure a plan that meets the residents' expectations of follow-up during and after resident council meeting where grievances have been advanced. A monthly audit during resident council meetings and/or in between could ensure effectiveness of the plan. Facility Administrator or social service designee could ensure that attempts have been made at a minimum of no less than a yearly basis to form a family counsel. Periodic surveys could be completed, such as during resident care conferences, to determine family interest, and any road blocks to the formation of such a counsel be explored with the leadership team. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21942		