



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: February 23, 2023

Dear Administrator:

On March 14, 2023, we notified you a remedy was imposed. On March 29, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 27, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 29, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 14, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 29, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 27, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: February 23, 2023

Dear Administrator:

On March 14, 2023, we informed you of imposed enforcement remedies.

On March 8, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 29, 2023, will remain in effect.

This Department continues to recommend that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 29, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 29, 2023.

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.

As we notified you in our letter of March 14, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 29, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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

Highland Operations LLC

March 16, 2023

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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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Highland Operations LLC

March 16, 2023

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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 August 23, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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:

Steven.Delich@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

Highland Operations LLC

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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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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March 16, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: Event ID: S8P911

Dear Administrator:

The above facility survey was completed on March 8, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 03/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2023
NAME OF PROVIDER OR SUPPLIER HIGHLAND OPERATIONS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/8/23, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H50288916C (MN91420), H50288917C (MN91332), H50288918C (MN91435), H50288749C (MN91236), and H5028151C (MN82485) with deficiencies issued at F684 and F677. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bathing and	F 677	R4 received bathing and grooming services on 3/15/2023. R4 ADL grooming		3/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2023

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

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F 677	Continued From page 1 grooming (shaving of facial hair) were completed for 1 of 3 residents (R4) reviewed for activities of daily living (ADL). Findings include: R4's quarterly Minimum Data Set (MDS) dated 2/10/23, indicated R4 was cognitively intact and required extensive assistance with personal hygiene. R4 did not exhibit rejection of care behaviors. R4's diagnoses included encephalopathy (disease that affects the brain), chronic obstructive pulmonary disease, (COPD/causes obstructed airflow from the lungs), congestive heart failure (CHF/when the heart fails to pump well) and morbid obesity (excessive body weight). R4's care plan dated 12/19/22, indicated R4 required extensive assistance for bathing/showering and personal hygiene. R4's ADL/Bathing task report with a look back of 30 days indicated R4 received a shower on 2/22/23 with not applicable marked on 2/8/23, 2/15/23, 2/17/23, 2/21/23, 3/1/23, 3/4/23, and 3/8/23. No other dates were listed. R4's unit bath schedule indicated R4 was scheduled for a bath on Wednesday day shift. R4's face sheet indicated R4 admitted to facility on 12/16/22. During observation on 3/8/23, at 10:45 a.m. R4 seated in a wheelchair in room had greasy hair and gray and black facial hair on chin and upper lip. The hair was several millimeters long.	F 677	care plan was reviewed and updated as needed. All existing resident bathing schedules were reviewed with facility staff and residents and bathing schedules adjusted per resident preference. Future residents who admit to the facility, the facility staff will meet with the resident and schedule bathing services and create a ADL care plan and the plan will be implemented. Nursing staff will be in-service on the ADL policy and procedure with emphasis on resident's receiving assistance with ADL bathing and grooming care per resident preference. Director of Nursing and/or designee is responsible for compliance. Audits on ADL care completion, documentation and grooming and ADL care plan updates will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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

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F 677	Continued From page 2 During interview on 3/8/23, at 11:03 a.m. R4 stated had only one shower since admission. The shower occurred two weeks ago. R4 stated she preferred staff shave off her facial hair which was last done with her shower. R4 denied ever refusing showers or facial shaving. During interview on 3/8/23, at 1:37 p.m. R4 stated no one had offered a shower yet today. During interview on 3/8/23, at 1:56 p.m. nursing assistant (NA)-A stated she did not offer R4 a shower today as she was not assigned to her. NA-A could not recall if she was assigned to R4 last Wednesday but could not explain why she marked not applicable on R4's bath task record for last Wednesday. During interview on 3/8/23, at 1:58 p.m. NA-B stated being assigned to R4 today and did not offer a shower yet today. During interview on 3/8/23, at 2:00 p.m. NA-C stated staff were supposed to provide baths or showers to the residents according to the bath schedule for the unit. NA-C stated if a resident refused a bath or shower, the nurse would be notified. NA-C stated she would offer a bath or shower two more times during the shift and would document the refusal if the bath or shower was not completed. During interview on 3/8/23, at 2:04 p.m. director of nursing (DON) stated expectation was the bath or shower would be done weekly per the bath schedule and the NA should notify the nurse if refused. Facility policy Activities of Daily Living (ADLs),	F 677			

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F 677	Continued From page 3 Supporting dated 12/7/21, indicated, "Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." The policy further indicated refusal of care would be documented in the resident's clinical record.	F 677			
F 684 SS=D	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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assess and complete appropriate wound care for 1 of 2 residents (R1) reviewed for wounds. In addition the facility failed to ensure skin assessments were completed for 2 of 2 residents (R1, R4) reviewed for skin. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/27/23, indicated R1 had intact cognition, did not reject cares, required extensive assist for most activities of daily living (ADLs) and was frequently incontinent of bowel and bladder. The MDS	F 684	R1 wound has healed. R1 skin care plan will be reviewed and updated as needed. R1 NP will be contacted for further skin treatment products and R1 orders will be updated. Resident will be placed on weekly skin checks documentation x4 weeks to ensure skin remains intact. R4 continues with skin concerns and will remain on daily skin treatment until area resolves. R4 will also be placed on weekly skin check documentation x4 weeks after current area heals to ensure skin remains intact. All other residents who have wounds will have their skin		3/27/23

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F 684	Continued From page 4 further indicated R1 had diagnoses of muscle weakness, diabetes mellitus, and morbid obesity, and was not at risk of developing pressure ulcers, had no other skin problems including open lesions, surgical wounds, burns, skin tears, and moisture associated skin damage (MASD). R1's care plan dated 11/12/22, indicated R1 had a potential impairment to skin integrity and included interventions to apply barrier cream after each incontinent episode, keep skin clean and dry, and use of an alternating pressure mattress. R1's care plan dated 11/20/22, indicated R1 was at risk for pressure ulcer development related to immobility and included interventions to administer treatments as ordered and monitor for effectiveness, and a pressure relieving bed. R1's physician orders dated 1/16/23, indicated GNP Miconazorb AF 2% powder apply to affected areas (folds) three times a day for candidiasis (yeast infection) use on skin folds, buttocks, perinium (sic). R1's physician orders dated 1/16/23, indicated nystatin powder could be utilized as needed at the bedside. R1's Braden Scale for Predicting Pressure Sore Risk dated 2/10/23, indicated R1 was at high risk for pressure ulcer development. R1's quarterly resident review (form used for quarterly care conference) dated 2/10/23, indicated R1 did not have any pressure ulcers or other skin integrity issues. R1's progress note dated 2/26/23, indicated R1	F 684	checked weekly during wound rounds and again during bathing. Licensed nurses and nurse aides will be in-serviced on the Prevention of Pressure Injuries with emphasis on daily observation of skin during ADL care and skin assessments are completed 8hrs after admission to the facility. Director of Nursing and/or designee is responsible for compliance. Audits on daily and weekly skin checks and skin care interventions will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 684	Continued From page 5 had a small open area noticed on her buttocks, barrier cream was applied and nursing would continue to monitor the area. Review of R1's progress notes dated 2/26/23 to 3/8/23, lacked physician notification, wound assessments, measurements or follow up wound status. R1's physician progress note dated 3/4/23, indicated R1 requested normlgel AG (a debriding agent used for dry necrotic wounds) to apply to sores in perineum. The note indicated R1 did not have any skin lacerations, and there were no rashes or lesions on exposed skin. R1's weekly bath audit dated 3/7/23, indicated there were no new alterations in skin issues. The previous weekly bath audit form was completed 12/26/22. During interview and observation on 3/8/23, at 10:21 a.m. R1 had a bottle of Sarna lotion (a topical medication to relieve itching and pain) on her bedside table along with an orange bottle of zinc oxide 17% cream (a cream used to treat diaper rash), and miconazole powder (used to treat a yeast infection). R1 stated she has had sores on her bottom on and off since she was admitted and the most recent one was present for the last three or four weeks and was due to incontinence. R1 added the miconazorb was applied by the nursing assistants and was occasionally used on her bottom. During observation on 3/8/23, at 11:52 a.m. nursing assistant (NA)-B assisted R1 with cleaning her buttocks. R1 had a superficial open area with a red wound bed and approximately the size of a nickel to the right lower buttocks/upper thigh area. NA-B took the bottle of Sarna itch	F 684			

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F 684	Continued From page 6 lotion and applied the lotion on R1's buttocks including the open wound. During interview on 3/8/23, at 12:11 p.m. NA-B stated she applied cream whenever R1 used the bedpan and verified she applied Sarna versus the zinc oxide and used the zinc oxide two days ago. During interview on 3/8/23, at 1:38 p.m. NA-B stated R1 did not refuse cares. During interview on 3/8/23, at 1:39 p.m. registered nurse (RN)-B stated she was not aware R1 had a wound and R1's medications ordered included miconazole powder and zinc paste. RN-B stated wound assessments including measurements and pictures were documented under the skin and wound tab in the electronic medical record (EMR), and verified there was no documentation completed. RN-B stated, if a resident has a new wound, the nurse must update the physician and document the notification in a progress note. RN-B added wound measurements and a wound assessment were necessary because the zinc cream may not be the correct treatment and the physician would need to be consulted for orders. RN-B stated she would not expect the NA to apply Sarna lotion to the wound because Sarna is not used to treat wounds and the aide should not complete wound care. Further, RN-B verified the progress notes lacked documentation the physician was updated. During interview on 3/8/23, at 2:09 p.m. RN-B verified R1 had a wound to the right lower buttock/upper thigh. At 2:20 p.m. RN-B stated R1's wound was the size of a quarter and stated if the wrong medication is applied, the skin could open.	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 7 During interview on 3/8/23, at 2:31 p.m. the director of nursing (DON) stated she expected to be updated of new wounds, the nurse to assess the wound, update the physician, and obtain orders for wound care, and document the assessment and physician notification in the EMR. DON verified wounds should be measured when they are discovered and stated Sarna lotion should not go on a wound. DON verified the physician was not updated and no wound measurements or assessment were completed. During interview on 3/8/23, at 2:51 p.m. RN-B stated she was not certain what type of wound R1 had, added it could be a pressure ulcer and verified it was the first time she had seen the wound. During interview on 3/8/23, at 3:17 p.m. the nurse practitioner stated she did not see R1 on 3/8/23, and the use of Sarna lotion for wound care was not the preferred treatment and would not recommend use for wound care. During interview on 3/8/23, at 3:51 p.m. the DON verified the quarterly resident review dated 2/10/23 indicated R1 had no skin issues and stated the wound was acquired at the facility. R4's quarterly MDS dated 2/10/23, indicated R4 was cognitively intact and required extensive assistance with personal hygiene. R4 did not exhibit rejection of care behaviors. R4's diagnoses included encephalopathy (disease that affects the brain), chronic obstructive pulmonary disease, (COPD/causes obstructed airflow from the lungs), congestive heart failure (CHF/when the heart fails to pump well) and morbid obesity (excessive body weight).	F 684			

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F 684	Continued From page 8 R4's care plan dated 12/19/22, indicated R4 had actual impairment to skin integrity with a goal to maintain or develop clean and intact skin. The care plan further indicated R4 required extensive assistance for bathing/showering and personal hygiene. R4's Braden assessment dated 2/10/23, indicated R4 had mild risk for developing pressure ulcers. R4's quarterly Resident Review assessment (form used for quarterly care conference) dated 2/10/23, indicated R4 had intact skin. R4's ADL/Bathing task report with a look back of 30 days indicated R4 received a shower on 2/22/23 with not applicable marked on 2/8/23, 2/15/23, 2/17/23, 2/21/23, 3/1/23, 3/4/23, and 3/8/23. No other dates were listed. R4's unit bath schedule indicated R4 was scheduled for a bath on Wednesday day shift. R4's clinical record in point click care (PCC) lack evidence of weekly skin or bath assessments. R4's face sheet indicated R4 admitted to facility on 12/16/22. During observation on 3/8/23, at 10:45 a.m. R4 seated in a wheelchair in room had greasy hair and gray and black facial hair on chin and upper lip. The hair was several millimeters long. R4 had bilateral wraps on legs from ankle to knees. During interview on 3/8/23, at 11:03 a.m. R4 stated having only one shower since admission. That shower occurred two weeks ago. R4 stated	F 684			

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F 684	Continued From page 9 she preferred staff shave off her facial hair which was last done with her shower. R4 denied ever refusing showers or facial shaving. During interview on 3/8/23, at 1:37 p.m. R4 stated no one had offered a shower yet today. During interview on 3/8/23, at 1:39 p.m. registered nurse (RN)-A stated skin assessments were done weekly with showers. RN-A stated the shower would be completed per the bath schedule for the unit. NAs would notify the nurse after the shower or bath so the skin assessment could be completed. RN-A stated not being notified of any skin assessments due today (3/8/23). During interview on 3/8/23, at 1:56 p.m. nursing assistant (NA)-A stated she did not offer R4 a shower today as she was not assigned to her. NA-A could not recall if she was assigned to R4 last Wednesday but could not explain why she marked not applicable on R4's bath task record for last Wednesday. During interview on 3/8/23, at 1:58 p.m. NA-B stated being assigned to R4 today and did not offer a shower yet today. During interview on 3/8/23, at 2:00 p.m. NA-C stated staff were supposed to provide baths or showers to the residents according to the bath schedule for the unit. NA-C stated if a resident refused a bath or shower, the nurse would be notified. NA-C stated she would offer a bath or shower two more times during the shift and would document the refusal if the bath or shower was not completed.	F 684			

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F 684	Continued From page 10 During interview on 3/8/23, at 2:04 p.m. director of nursing (DON) stated expectation was that the bath or shower would be done weekly per the bath schedule and that a skin assessment was completed during that time. DON stated the NA should notify the nurse if refused. During interview on 3/8/23, at 3:56 p.m. DON confirm R4's clinical record lacked weekly skin and bath assessments. A policy Pressure Ulcers/Skin Breakdown dated 7/12/22, indicated the physician will assist the staff to identify the type and characteristics of an ulcer and the physician will identify factors contributing or predisposing residents to skin breakdown and the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. A policy Acute Condition Changes-Clinical Protocol dated 11/30/21, indicated prior to contacting a physician, nursing staff will collect pertinent details to report to the physician including a resident's current symptoms and status. Nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The physician will help identify and authorize appropriate treatments. The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly. Facility policy Activities of Daily Living (ADLs), Supporting dated 12/7/21, indicated, "Residents will be provided with care, treatment, and	F 684			

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F 684	Continued From page 11 services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." The policy further indicated refusal of care would be documented in the resident's clinical record. A facility policy on skin assessments was requested but not received. A facility policy on bathing/showering was requested by not received. A policy on medication administration was requested, but not received.	F 684			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/08/2023
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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 3/8/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure The following complaints were reviewed during the survey:		2 000		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

03/17/23

Minnesota Department of Health

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2 000	Continued From page 1 H50288916C (MN91420) H50288917C (MN91332) H50288918C (MN91435) H50288749C (MN91236) H5028151C (MN82485) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			