DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2020

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: CCN: 245052
Survey Start Date: November 7, 2019

Dear Administrator:

On July 30, 2020 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 July 14, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
June 3, 2020

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

SUBJECT: SURVEY RESULTS
CCN: 245052
Cycle Start Date: November 7, 2019

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 19, 2020, the Minnesota Department of Health completed a complaint investigation at Moorhead Rehabilitation & Healthcare Center to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

A plan of correction is not needed for Tag F 689 because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 19, 2020 survey. Moorhead Rehabilitation & Healthcare Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 19, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Moorhead Rehabilitation & Healthcare Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	C 05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

(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 5/15, 5/18 and 5/19/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5052116C. Deficiency cited at F689, F609, F607 and F580. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		6/26/20

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

Electronically Signed | 06/12/2020

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F 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the physician was notified when a resident's condition changed for 1 of 1 residents (R1) who acquired a second degree burn from a nebulizer machine. Finding include: R1's discharge return anticipated Minimum Data Set (MDS) dated 4/16/20, identified R1 had severe cognitive impairment and required total assistance from staff for activities of daily living (ADL's) of transfers, bed mobility, dressing, toileting, personal hygiene, bathing and eating. R1's MDS did not identify her ability to communicate and indicated she had no skin issues. R1's quarterly MDS dated 1/3/20, identified R1 had diagnoses which included Diabetes Mellitus, cerebral ischemia (a blockage in an artery to the brain, resulting in damage to brain tissue) , hemiplegia and hemiparesis affecting right dominate side and had severe cognitive impairment. The MDS indicated R1 was totally dependent on staff for ADL's of transfers, bed mobility, toileting, and dressing, did not eat and utilized a feeding tube for nutrition. The MDS did not identify R1's ability to communicate, and indicated R1 was at risk for pressure ulcers, and had no skin issues. R1's care plan, revised 5/8/20, revealed R1 had skin impairment of the right thigh related to rupture of fluid filled blister, altered respiratory status/difficulty breathing related to aspiration pneumonia and staff were to administer	F 580	R 1 MD was notified of the wound on 5/5/2020. R 1 wound healed on 5/19/2020. A new comprehensive skin assessment was completed, and her care plan was reviewed and updated as needed. All other residents who had changes in conditions charts were reviewed from date of exit until present and any changes of condition that the MD was not aware of will be notified and charted. All non-compliance will be immediately corrected. IDT team will review daily documentation to ensure compliance. Nursing staff will be educated on MD notification in change of condition policy and procedure beginning 6/17/2020. Director of Nursing or designee is responsible for compliance. Audits on change in condition MD notification will begin 6/17/2020 weekly x 3 weeks then monthly to ensure compliance. All audits will be reviewed by the Administrator then taken to QAPI for review and recommendation. Compliance: 06/26/2020	

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F 580	Continued From page 3	F 580		

medication/puffers as ordered. The care plan indicated R1 required total assistance with transfers, repositioning, bed mobility, toileting, personal hygiene had impaired communication and staff were anticipate and meet her needs.

On 5/15/20 at 3:01 p.m. registered nurse (RN)-A stated he had worked the evening shift on 4/30/20, and had entered R1's room at approximately 4:00 p.m. and found a nebulizer machine on her bed, immediately adjacent to her right thigh. RN-A stated the nebulizer machine was turned on and running on her bed next to R1's right thigh. He indicated R1 was totally dependent on staff for all of her needs and received daily nebulizer treatments. RN-A indicated he removed the nebulizer from R1's bed, placed the nebulizer on the floor and left the room. RN-A indicated later that evening an NA notified him R1 had blisters on her right thigh. RN-A confirmed he observed 2 small blisters on her right thigh and indicated he was unsure of what caused them or how long they had been there. RN-A indicated he got busy with another resident and did not notify the doctor or nurse manager, although he did report the incident to another nurse, LPN-C, at shift change.

On 5/18/19 at 10:22 a.m. during a telephone interview with LPN-B, he indicated on 4/30/20 at approximately 12 noon, he had administered R1's breathing medication via nebulizer, had placed a face mask on R1's face, turned on the machine and had left the room. LPN-B stated he got distracted with another resident and had not returned to R1's room. He stated R1 was totally dependent on staff for all ADL's and indicated she was non verbal and received daily nebulizer treatments. LPN-B indicated he did not remember

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F 580	Continued From page 4	F 580		

having placed the nebulizer on R1's bed, next to R1's right thigh. LPN-B indicated on that day his routine "was messed up" and did he could not recall if he had returned to R1's room to turn the nebulizer off. LPN-B stated the normal practice when would be to stay with R1 when he administered her nebulized medication and indicated the nebulizer machine should be on the night stand while running, not on R1's bed.

R1's Incident Report dated 5/4/20, identified R1 had a 7.5 centimeters (cm) long x 4.5 cm wide blister of unknown origin. The incident report identified R1's blister was located on her right anterior lateral thigh, had erythema (superficial reddening of the skin, as a result of injury or irritation) extending from the blister. The incident report had two smaller red areas at the posterior, medial aspect of the blister as well. The report identified R1's physician had been notified of R1's injury that day.

R1's Progress Notes from 5/3/20 to 5/4/20 revealed the following:

- 5/3/20, at 12:30 a.m. large blister noted to upper right thigh measured 7.5 cm in length by 4.5 cm wide, blister bubble was 1.5 cm high, surrounding tissue showed no signs or symptoms of infection.

- 5/3/20, at 1:43 a.m. writer discussed blister with coworker who had worked R1's unit recently and coworker stated the nebulizer machine had been placed on bed while in use and the air/vibration of the machine agitated the skin, which caused a blister. The coworker was unsure of when this event had occurred. The note revealed the author would follow up with staff in the morning for more clarification.

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F 580	Continued From page 5	F 580		

- 5/4/20 at 4:31 p.m. physician progress note: indicated she had been asked to evaluate R1 for the skin injury with blister to right thigh. The note indicated staff were unaware when the blister developed, but had been reported that day. A very large blister was present on her right anterior lateral thigh which measured 7.5 cm x 4.5 cm. There was erythema extending from the blister, but the area was not warm to touch and there was two small areas at the posterior, medial aspect of the blister. There had been unconfirmed reports a nebulizer was placed on R1's bed that fell on R1 and was possible source of injury. The area was suspicious for burn verses friction as the two areas to the posterior medial aspect could have come from the foot of the nebulizer machine.

On 5/18/20 at 1:45 p.m. director of nursing (DON) reviewed R1's medical record and confirmed R1 had sustained a blister to her right thigh from a nebulizer being left running in her bed. The DON indicated she would expect staff to remain with R1 while she received her treatment, and the nebulizer machine to be placed on a flat surface like a table or night stand when the treatment was being administered. The DON stated she had not been made aware of R1's blister and had found out when she had completed her routine review of resident medical records on 5/4/20. The DON stated she expected to have been notified immediately of R1's blistered injury and would expect R1's physician to have been notified when the injury occurred, on 4/30/20.

On 5/18/20 at 2:19 p.m. administrator confirmed R1 sustained a second degree burn to her right thigh because staff had left a nebulizer machine

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F 580	Continued From page 6	F 580		

running on R1's bed. The administrator indicated she would expect staff to assess the resident wound after the incident, contact the doctor and contact the DON or herself to report the incident when it first occurred.

On 5/18/20 at 3:18 p.m. LPN-C stated R1 was totally dependent on staff, was unable to verbalize her needs or wishes and received daily nebulizer treatments. LPN-C stated on 4/30/20, RN-A had instructed her "not to leave R1's nebulizer machine on her bed," and had been told R1's nebulizer should be kept on the night stand during administration. LPN-C indicated on 4/30/20, RN-A was aware of R1's thigh injury and had taken LPN-C into the room to observe the area. LPN-C indicated she had not assessed R1's thigh wound or notified her primary physician or the DON and had been under the impression RN-A had done those things. LPN-C indicated normal practice was to assess the resident, stay with the resident when administering a nebulizer treatment and to make sure the nebulizer was placed on the night stand during administration.

On 5/18/20 at 3:40 p.m. during telephone interview with R1's medical doctor (MD)-A she had indicated staff notified her of R1's large skin lesion which measured 4 to 5 cm and blistered. MD-A indicated she had reviewed R1's recent hospital records and there had been no documentation of a skin lesion and she did not know how the blister had occurred. MD-A indicated the facility notified her of R1's blister on 5/4/20, and the facility had not told her the cause of the blister. MD-A indicated the wound was draining with no inflammation and she ordered dressing changes to wound. MD-A indicated she had seen R1 again on 5/7/20, and she thought

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F 580	Continued From page 7 the wound was infected and ordered Augmentin (antibiotic). MD-A indicated in her clinical opinion the heat from the nebulizer left on for hours could have caused this type of injury. Review of the facility's undated policy, Change in Resident Condition or Status undated, indicated the facility staff were to promptly notify the resident, attending physician and representative of changes in the resident's medical/mental condition and or status.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement and provide facility specific abuse prevention training to 2 of 3 employees (E1, E3) who were reviewed for abuse training during the survey. This had the potential to affect all 29 resident currently residing in the facility. Findings include:	F 607	F 607 E 1 and E 3 were in-serviced on the abuse reporting policy and procedure on 5/18 and 5/19/2020. Existing employee files were reviewed and those employee□s that have not received abuse training will be educated. Upon hire, employees will continue to receive abuse training upon hire and yearly. For any subsequent reports of	6/26/20

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F 607	Continued From page 8 Review of the provided policy titled, Preventing Resident Abuse updated on 6/9/19, indicated the facility would not condone any form of resident abuse and would continually monitor the facility's policies, procedures, training program, systems, to assist in preventing resident abuse and to train all facility staff. The policy identified mandated staff training/orientation programs included such topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions, protection of residents and investigation process. 5/18/20, at 10:22 a.m. E3 indicated he would report abuse to the state immediately within 24 hours, notify the administrator and they would "take care of it." E3 could not remember if he had received abuse training when he was hired. On 5/18/20, at 3:18 p.m. E1 confirmed she had recently been hired by the facility in April 2020, and had not received any abuse training since she was hired. E1 indicated she would report any type of abuse to the director of nursing (DON) and the administrator and report it to the state within one hour. On 5/18/20, at 4:00 p.m. E1 and E3's employee files were reviewed. Both employees personnel files lacked documentation of Abuse prevention training. The facility had no record or evidence E1 and E3 had received abuse prevention policies and procedures when they were both recently hired. On 5/18/20, at 2:50 p.m. the administrator confirmed both E1 and 3 had not received abuse training when they were hired. The administrator indicated the usual practice was for employees to	F 607	abuse, staff will be in-serviced the day of report for 3 subsequent shifts to ensure compliance. Social services Director or designee is responsible for compliance. Audits on employee abuse training will begin 6/17/2020 weekly x 3 weeks and monthly to ensure compliance. Audits will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 06/26/2020	

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F 607	Continued From page 9 receive abuse training on orientation, annually or as needed. The administrator indicated the social worker was responsible to making sure the abuse training was done for the employees.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 609	F 609	7/15/20

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F 609	Continued From page 10 facility failed to immediately report to the administrator and immediately report, no later than 24 hours, to the State Agency (SA) an incident of neglect of care for 1 of 1 resident (R1) reviewed for neglect of care. Findings include: R1's discharge return anticipated Minimum Data Set (MDS) dated 4/16/20, identified R1 had severe cognitive impairment and required total assistance from staff for for activities of daily living (ADL's) of transfers, bed mobility, dressing, toileting, personal hygiene, bathing and eating. R1's MDS did not identify her ability to communicate and indicated she had no skin issues. R1's quarterly MDS dated 1/3/20, identified R1 had diagnoses which included Diabetes Mellitus, cerebral ischemia (a blockage in an artery to the brain, resulting in damage to brain tissue) , hemiplegia and hemiparesis affecting right dominate side and had severe cognitive impairment. The MDS indicated R1 was totally dependent on staff for ADL's of transfers, bed mobility, toileting, and dressing, did not eat and utilized a feeding tube for nutrition. The MDS did not identify R1's ability to communicate, and indicated R1 was at risk for pressure ulcers, and had no skin issues. R1's care plan, revised 5/8/20, revealed R1 had skin impairment of the right thigh related to rupture of fluid filled blister, altered respiratory status/difficulty breathing related to aspiration pneumonia and staff were to administer medication/puffers as ordered. The care plan did not address the use of a nebulizer for R1.	F 609	R 1 incident was reported to the state agency on 5/4/2020. All other abuse incidents as of this writing notification was timely. Grievances and daily documentation will be reviewed for any indications of abuse not reported. Any allegation or grievance noted with an allegation will be reported. Residents will be educated on abuse reporting at the next resident council scheduled for 6/22/2020. Staff will be in-serviced on facility reporting abuse policy and procedure on 06/17/2020. Abuse coordinator poster was updated to include abuse coordinator number. Social Services Director or designee is responsible for compliance. Audits on timely reporting of allegations of abuse will begin 3x week x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 07/15/2020	

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F 609	Continued From page 11 On 5/15/20 at 3:01 p.m. registered nurse (RN)-A stated he had worked the evening shift on 4/30/20, and had entered R1's room at approximately 4:00 p.m. and found a nebulizer machine on her bed, immediately adjacent to her right thigh. RN-A stated the nebulizer machine was turned on and running on her bed next to R1's right thigh. He indicated R1 was totally dependent on staff for all of her needs and received daily nebulizer treatments. RN-A indicated he removed the nebulizer from R1's bed, placed the nebulizer on the floor and left the room. RN-A indicated later that evening an NA notified him R1 had blisters on her right thigh. RN-A confirmed he observed 2 small blisters on her right thigh and indicated he was unsure of what caused them or how long they had been there. RN-A indicated he got busy with another resident and did not notify the doctor or nurse manager, although he did report the incident to another nurse, LPN-C, at shift change. R1's progress note dated 5/3/20, at 12:30 a.m. identified R1 had a large blister noted to upper right thigh measured 7.5 cm in length by 4.5 cm wide, blister bubble was 1.5 cm high, surrounding tissue showed no signs or symptoms of infection. - a later note, at 1:43 a.m. writer discussed blister with coworker who had worked R1's unit recently and coworker stated the nebulizer machine had been placed on bed while in use and the air/vibration of the machine agitated the skin, which caused a blister. The coworker was unsure of when this event had occurred. The note revealed the author would follow up with staff in the morning for more clarification.	F 609		

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R1's Incident Report dated 5/4/20, identified R1 had a 7.5 centimeters (cm) long x 4.5 cm wide blister of unknown origin. The incident report identified R1's blister was located on her right anterior lateral thigh, had erythema (superficial reddening of the skin, as a result of injury or irritation) extending from the blister. The incident report had two smaller red areas at the posterior, medial aspect of the blister as well.

Review of the facility submitted SA report dated 5/4/20, at 4:08 p.m. identified R1 had sustained a blistered area with an unknown etiology. The report revealed the facility had begun an investigation.

On 5/18/20 at 1:45 p.m. director of nursing (DON) reviewed R1's medical record and confirmed R1 had sustained a blister to her right thigh from a nebulizer being left running in her bed. The DON stated she had first been made aware of R1's blister during a routine record review following the previous weekend. The DON confirmed she had not been aware of R1's injury with blister prior to 5/4/20. The DON confirmed she had reported R1's blister of unknown etiology to that day.

On 5/18/20 at 2:19 p.m. administrator confirmed R1 sustained a second degree burn to her right thigh because staff had left a nebulizer machine running on R1's bed. The administrator confirmed she had not been aware of R1's second degree burn until the DON had notified her on 5/4/20. The administrator stated she would expect staff to immediately have reported the incident to the DON and herself when the incident had occurred.

Review of the facility policy titled, Abuse Investigations reviewed on 4/24/20, indicated

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F 609	Continued From page 13 should an incident or suspected incident of resident abuse, mistreatment, neglect, exploitation or mistreatment, including injuries of unknown source be reported to , the administrator , or his/her designee, will initiate OHFC stated report immediately but no later that 2 hours after the allegation was made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later that 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Any reasonable suspicion of crime is also to be reported to law enforcement within this time frame.	F 609		
F 689 SS=G	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 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate supervision to prevent accident hazards during the use of a nebulizer machine for 1 of 1 resident (R1) who was dependent on staff and was left unattended with a running nebulizer machine in her bed and on right thigh. This deficient practice caused actual harm to R1 when a second degree burn was sustained on her right upper thigh and subsequently became infected. The facility had implemented corrective action on 5/8/20, the	F 689	Past noncompliance: no plan of correction required.	6/12/20

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deficient practice is being issued at harm level, past non-compliance.

Finding include:

R1's discharge return anticipated Minimum Data Set (MDS) dated 4/16/20, identified R1 had severe cognitive impairment and required total assistance from staff for activities of daily living (ADL's), transfers, bed mobility, dressing, toileting, personal hygiene, bathing and eating. R1's MDS did not identify her ability to communicate and indicated she had no skin issues.

R1's quarterly MDS dated 1/3/20, identified R1 had diagnoses which included diabetes mellitus, cerebral ischemia (a blockage in an artery to the brain, resulting in damage to brain tissue), hemiplegia and hemiparesis affecting right dominate side and had severe cognitive impairment. The MDS indicated R1 was totally dependent on staff for ADL's of transfers, bed mobility, toileting, and dressing, did not eat and utilized a feeding tube for nutrition. The MDS did not identify R1's ability to communicate, and indicated R1 was at risk for pressure ulcers, and had no skin issues.

R1's care plan, revised 5/8/20, revealed R1 had skin impairment of the right thigh related to rupture of fluid filled blister, altered respiratory status/difficulty breathing related to aspiration pneumonia and staff were to administer medication/puffers as ordered. The care plan indicated R1 required total assistance with transfers, repositioning, bed mobility, toileting, personal hygiene, had impaired communication and staff were to anticipate and meet her needs.

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On 5/15/20 at 3:01 p.m. registered nurse (RN)-A stated he had worked the evening shift on 4/30/20, and had entered R1's room at approximately 4:00 p.m. and found a nebulizer machine on her bed, immediately adjacent to her right thigh. RN-A stated the nebulizer machine was turned on and running on her bed next to R1's right thigh. He indicated R1 was totally dependent on staff for all of her needs and received daily nebulizer treatments. RN-A indicated he removed the nebulizer from R1's bed, placed the nebulizer on the floor and left the room. RN-A indicated later that evening an NA notified him R1 had blisters on her right thigh. RN-A confirmed he observed 2 small blisters on her right thigh and indicated he was unsure of what caused them or how long they had been there. RN-A indicated he got busy with another resident and did not notify the doctor or nurse manager, although he did report the incident to another nurse, LPN-C, at shift change.

On 5/18/19 at 10:22 a.m. during a telephone interview with LPN-B, he indicated on 4/30/20, at approximately 12 noon, he had administered R1's breathing medication via nebulizer, had placed a face mask on R1's face, turned on the machine and had left the room. LPN-B stated he got distracted with another resident and had not returned to R1's room. He stated R1 was totally dependent on staff for all ADL's and indicated she was non verbal and received daily nebulizer treatments. LPN-B indicated he did not remember having placed the nebulizer on R1's bed, next to R1's right thigh. LPN-B indicated on that day his routine "was messed up" and he could not recall if he had returned to R1's room to turn the nebulizer off. LPN-B stated the normal practice

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would be to stay with R1 when he administered her nebulized medication and indicated the nebulizer machine should be on the night stand while running, not on R1's bed.

During observation on 5/18/20, at 11:27 a.m. R1 laid in bed on her back, covered with blankets and the head of her bed slightly elevated. At that time, licensed practical nurse (LPN)-A and nursing assistant (NA)-A entered R1's room. LPN-A uncovered R1's right side, and removed a soiled beige colored dressing, dated 5/15/20, from her thigh. The beige dressing had a scant amount of serosanguinous drainage noted on it. LPN-A measured R1's right thigh wound, which measured 6 cm x 4 cm wide, wound bed was dry, no drainage, pink in color with a few white spots in middle of wound bed, the outer edges were intact, dry and flaky. LPN-A proceeded to cleanse and apply a new dressing to R1's right thigh wound and proceeded to administer a nebulizer treatment to R1.

R1's Incident Report dated 5/4/20, identified R1 had a 7.5 centimeters (cm) long x 4.5 cm wide blister of unknown origin. The incident report identified R1's blister was located on her right anterior lateral thigh, had erythema (superficial reddening of the skin, as a result of injury or irritation) extending from the blister. The Incident Report had two smaller red areas at the posterior, medial aspect of the blister as well.

R1's Order Summary Report dated 4/30/20, indicated an order for Ipratropium-Albuterol solution (medication used to open airways) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) one vial inhale orally four times a day for spasms of the lung air passages. The Order Summary

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Report did not address the use of a nebulizer for R1.

R1's Progress Notes from 4/28/20 to 5/19/20, revealed the following:

- 4/28/20, re-admitted from hospital, after sepsis secondary to aspiration pneumonia and urinary tract infection, lungs sounds clear, orientation could not be assessed due to vegetative state. New stage two pressure ulcer present to her sacrum, however, did not identify any other skin alterations.

- 5/3/20, at 12:30 a.m. large blister noted to upper right thigh measured 7.5 cm in length by 4.5 cm wide, blister bubble was 1.5 cm high, surrounding tissue showed no signs or symptoms of infection.

- 5/3/20, at 1:43 a.m. writer discussed blister with coworker who had worked R1's unit recently and coworker stated the nebulizer machine had been placed on bed while in use and the air/vibration of the machine agitated the skin, which caused a blister. The coworker was unsure of when this event had occurred. The note revealed the author would follow up with staff in the morning for more clarification.

- 5/4/20 at 4:31 p.m. physician progress note indicated she had been asked to evaluate R1 for the skin injury with blister to right thigh. The note indicated staff were unaware when the blister developed, but had been reported that day. A very large blister was present on her right anterior lateral thigh which measured 7.5 cm x 4.5 cm. There was erythema extending from the blister, but the area was not warm to touch and there was two small areas at the posterior, medial

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aspect of the blister. There had been unconfirmed reports a nebulizer was placed on R1's bed that fell on R1 and was possible source of injury. The area was suspicious for burn verses friction as the two areas to the posterior medial aspect could have come from the foot of the nebulizer machine.

- 5/5/20, blister had no drainage, was covered with a Mepilex dressing (absorbent foam dressing). The note revealed staff would continue to monitor R1's blister. A later note at 1:45 p.m. indicated R1 was seen by her primary medical doctor (MD) via zoom regarding blister on posterior right thigh. Blister was now opened and draining, Mepilex dressing intact.

- 5/7/20, seen by her primary MD via zoom regarding right thigh blister. The note revealed an order was given for Augmentin (antibiotic) tablet 875-125 milligrams (mg) for prophylactic for seven days twice a day.

- 5/8/20, blister on right thigh had opened and had "turned into a wound."

- 5/11/20, wound assessment completed, no complaints of pain during assessment, incorrectly identified R1 had stage two non pressure related wound, to posterior right thigh which had improved dramatically from last week. The wound measurement 6.5 cm x 4.5 cm x 0 cm, with defined edges, brown/cream in color, warm upon palpation, no drainage noted, and no odor. R1 was currently on antibiotic prophylaxis and Mepilex dressing every third day and as needed.

On 5/18/20 at 1:45 p.m. director of nursing (DON) reviewed R1's medical record and confirmed R1

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had sustained a blister to her right thigh from a nebulizer being left running in her bed. The DON indicated she would expect staff to remain with R1 while she received her treatment, and the nebulizer machine to be placed on a flat surface like a table or night stand when the treatment was being administered. She indicated R1 required staff assistance with all her ADL's, and received nebulizer treatments routinely throughout each day.

On 5/18/20 at 2:19 p.m. administrator confirmed R1 sustained a second degree burn to her right thigh because staff had left a nebulizer machine running on R1's bed. The administrator indicated she would expect staff to assess the resident wound after the incident, contact the doctor, DON and herself to report the incident when it first occurred.

On 5/18/20 at 3:18 p.m. LPN-C stated R1 was totally dependent on staff, was unable to verbalize her needs or wishes and received daily nebulizer treatments. LPN-C stated on 4/30/20, RN-A had instructed her "not to leave [R1'] nebulizer machine on her bed," and had been told R1's nebulizer should be kept on the night stand during administration. LPN-C indicated on 4/30/20, RN-A was aware of R1's thigh injury and had taken LPN-C into the room to observe the area. LPN-C indicated she had not assessed R1's thigh wound or notified her primary physician or the DON and had been under the impression RN-A had done those things. LPN-C indicated normal practice was to assess the resident, stay with the resident when administering a nebulizer treatment and to make sure the nebulizer was placed on the night stand during administration.

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On 5/18/20 at 3:40 p.m. during telephone interview with R1's medical doctor (MD)-A she had indicated staff notified her of R1's large skin lesion which measured 4 to 5 cm and blistered. MD-A indicated she had reviewed R1's recent hospital records and there had been no documentation of a skin lesion and she did not know how the blister had occurred. MD-A indicated the facility notified her of R1's blister on 5/4/20, and the facility had not told her the cause of the blister. MD-A indicated the wound was draining with no inflammation and she ordered dressing changes to wound. MD-A indicated she had seen R1 again on 5/7/20, and she thought the wound was infected and ordered Augmentin (antibiotic). MD-A indicated in her clinical opinion the heat from the nebulizer left on for hours could have caused this type of injury.

Review of the Aeromist Colors Nebulizer Compressor Kit Instructions Manual, undated, indicated under warnings: never block the air opening of the product or place it on a soft surface, such as bed or couch, when the air opening may be blocked. Under operating instructions: place compressor on a stable, sturdy and flat surface.

Review of facility policy titled, Administering Medication Through A Small Volume (handheld) Nebulizer, reviewed on 5/8/20, indicated assemble equipment and supplies on the residents's over bed table, assemble nebulizer equipment and attach to the source of gas per manufactures instructions and remain with the resident for the treatment.

Review of facility policy titled, Accidents And Incidents- Investigating And Reporting, updated

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F 689	Continued From page 21 on 6/9/19, indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The past non-compliance that began on 4/30/20, was verified during the 5/15/20, onsite visit and was corrected by the facility on 5/8/20. The verification of corrective action was confirmed by interview with a variety of nursing staff, residents and observation of residents who utilized nebulizer treatments, in addition to documentation of education provided to the nursing staff. On 5/8/20, the facility had retrained the licensed nursing staff on the Administration Medication Through a Small Volume Nebulizer policy, Accident and Incident-Investigating and Reporting policy, Weekly Skin Evaluation policy, Charting and Documentation policy, and notification of change protocol.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2020

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

Re: State Nursing Home Licensing Orders
Event ID: S1F611

Dear Administrator:

The above facility was surveyed on May 15, 2020 through May 19, 2020 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:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00938	A. BUILDING: _____ B. WING _____	C 05/19/2020

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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 5/15, 5/18 and 5/19/2020 surveyors of this Department's staff visited the above provider for a complaint investigation to investigate complaint H5052116C and were found to be substantiated. The complaint was substantiated and the following correction orders are issued. Please indicate in your electronic plan of correction that	2 000		

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2 000	Continued From page 1 you have reviewed these orders, and identify the date when they will be completed. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to	2 265		6/26/20

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2 265	Continued From page 2 begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the physician was notified when a resident's condition changed for 1 of 1 residents (R1) who acquired a second degree burn from a nebulizer machine. Finding include: R1's discharge return anticipated Minimum Data Set (MDS) dated 4/16/20, identified R1 had severe cognitive impairment and required total assistance from staff for activities of daily living (ADL's) of transfers, bed mobility, dressing, toileting, personal hygiene, bathing and eating. R1's MDS did not identify her ability to communicate and indicated she had no skin issues. R1's quarterly MDS dated 1/3/20, identified R1 had diagnoses which included Diabetes Mellitus, cerebral ischemia (a blockage in an artery to the brain, resulting in damage to brain tissue) , hemiplegia and hemiparesis affecting right dominate side and had severe cognitive impairment. The MDS indicated R1 was totally dependent on staff for ADL's of transfers, bed mobility, toileting, and dressing, did not eat and utilized a feeding tube for nutrition. The MDS did not identify R1's ability to communicate, and indicated R1 was at risk for pressure ulcers, and	2 265	Corrected	

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2 265	Continued From page 3	2 265		

had no skin issues.

R1's care plan, revised 5/8/20, revealed R1 had skin impairment of the right thigh related to rupture of fluid filled blister, altered respiratory status/difficulty breathing related to aspiration pneumonia and staff were to administer medication/puffers as ordered. The care plan indicated R1 required total assistance with transfers, repositioning, bed mobility, toileting, personal hygiene had impaired communication and staff were anticipate and meet her needs.

On 5/15/20 at 3:01 p.m. registered nurse (RN)-A stated he had worked the evening shift on 4/30/20, and had entered R1's room at approximately 4:00 p.m. and found a nebulizer machine on her bed, immediately adjacent to her right thigh. RN-A stated the nebulizer machine was turned on and running on her bed next to R1's right thigh. He indicated R1 was totally dependent on staff for all of her needs and received daily nebulizer treatments. RN-A indicated he removed the nebulizer from R1's bed, placed the nebulizer on the floor and left the room. RN-A indicated later that evening an NA notified him R1 had blisters on her right thigh. RN-A confirmed he observed 2 small blisters on her right thigh and indicated he was unsure of what caused them or how long they had been there. RN-A indicated he got busy with another resident and did not notify the doctor or nurse manager, although he did report the incident to another nurse, LPN-C, at shift change.

On 5/18/19 at 10:22 a.m. during a telephone interview with LPN-B, he indicated on 4/30/20 at approximately 12 noon, he had administered R1's breathing medication via nebulizer, had placed a face mask on R1's face, turned on the machine

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2 265	Continued From page 4	2 265		

and had left the room. LPN-B stated he got distracted with another resident and had not returned to R1's room. He stated R1 was totally dependent on staff for all ADL's and indicated she was non verbal and received daily nebulizer treatments. LPN-B indicated he did not remember having placed the nebulizer on R1's bed, next to R1's right thigh. LPN-B indicated on that day his routine "was messed up" and did he could not recall if he had returned to R1's room to turn the nebulizer off. LPN-B stated the normal practice when would be to stay with R1 when he administered her nebulized medication and indicated the nebulizer machine should be on the night stand while running, not on R1's bed.

R1's Incident Report dated 5/4/20, identified R1 had a 7.5 centimeters (cm) long x 4.5 cm wide blister of unknown origin. The incident report identified R1's blister was located on her right anterior lateral thigh, had erythema (superficial reddening of the skin, as a result of injury or irritation) extending from the blister. The incident report had two smaller red areas at the posterior, medial aspect of the blister as well. The report identified R1's physician had been notified of R1's injury that day.

R1's Progress Notes from 5/3/20 to 5/4/20 revealed the following:

- 5/3/20, at 12:30 a.m. large blister noted to upper right thigh measured 7.5 cm in length by 4.5 cm wide, blister bubble was 1.5 cm high, surrounding tissue showed no signs or symptoms of infection.

- 5/3/20, at 1:43 a.m. writer discussed blister with coworker who had worked R1's unit recently and coworker stated the nebulizer machine had been placed on bed while in use and the air/vibration of

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2 265	Continued From page 5 the machine agitated the skin, which caused a blister. The coworker was unsure of when this event had occurred. The note revealed the author would follow up with staff in the morning for more clarification. - 5/4/20 at 4:31 p.m. physician progress note: indicated she had been asked to evaluate R1 for the skin injury with blister to right thigh. The note indicated staff were unaware when the blister developed, but had been reported that day. A very large blister was present on her right anterior lateral thigh which measured 7.5 cm x 4.5 cm. There was erythema extending from the blister, but the area was not warm to touch and there was two small areas at the posterior, medial aspect of the blister. There had been unconfirmed reports a nebulizer was placed on R1's bed that fell on R1 and was possible source of injury. The area was suspicious for burn verses friction as the two areas to the posterior medial aspect could have come from the foot of the nebulizer machine. On 5/18/20 at 1:45 p.m. director of nursing (DON) reviewed R1's medical record and confirmed R1 had sustained a blister to her right thigh from a nebulizer being left running in her bed. The DON indicated she would expect staff to remain with R1 while she received her treatment, and the nebulizer machine to be placed on a flat surface like a table or night stand when the treatment was being administered. The DON stated she had not been made aware of R1's blister and had found out when she had completed her routine review of resident medical records on 5/4/20. The DON stated she expected to have been notified immediately of R1's blistered injury and would expect R1's physician to have been notified when the injury occurred, on 4/30/20.	2 265		

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2 265	Continued From page 6 On 5/18/20 at 2:19 p.m. administrator confirmed R1 sustained a second degree burn to her right thigh because staff had left a nebulizer machine running on R1's bed. The administrator indicated she would expect staff to assess the resident wound after the incident, contact the doctor and contact the DON or herself to report the incident when it first occurred. On 5/18/20 at 3:18 p.m. LPN-C stated R1 was totally dependent on staff, was unable to verbalize her needs or wishes and received daily nebulizer treatments. LPN-C stated on 4/30/20, RN-A had instructed her "not to leave R1's nebulizer machine on her bed," and had been told R1's nebulizer should be kept on the night stand during administration. LPN-C indicated on 4/30/20, RN-A was aware of R1's thigh injury and had taken LPN-C into the room to observe the area. LPN-C indicated she had not assessed R1's thigh wound or notified her primary physician or the DON and had been under the impression RN-A had done those things. LPN-C indicated normal practice was to assess the resident, stay with the resident when administering a nebulizer treatment and to make sure the nebulizer was placed on the night stand during administration. On 5/18/20 at 3:40 p.m. during telephone interview with R1's medical doctor (MD)-A she had indicated staff notified her of R1's large skin lesion which measured 4 to 5 cm and blistered. MD-A indicated she had reviewed R1's recent hospital records and there had been no documentation of a skin lesion and she did not know how the blister had occurred. MD-A indicated the facility notified her of R1's blister on 5/4/20, and the facility had not told her the cause of the blister. MD-A indicated the wound was	2 265		

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2 265	Continued From page 7 draining with no inflammation and she ordered dressing changes to wound. MD-A indicated she had seen R1 again on 5/7/20, and she thought the wound was infected and ordered Augmentin (antibiotic). MD-A indicated in her clinical opinion the heat from the nebulizer left on for hours could have caused this type of injury. Review of the facility's undated policy, Change in Resident Condition or Status undated, indicated the facility staff were to promptly notify the resident, attending physician and representative of changes in the resident's medical/mental condition and or status. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to appropriate notification of change of condition and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		
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	2 830		6/26/20

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2 830	Continued From page 8 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 adequate supervision to prevent accident hazards during the use of a nebulizer machine for 1 of 1 resident (R1) who was dependent on staff and was left unattended with a running nebulizer machine in her bed and on right thigh. This deficient practice caused actual harm to R1 when a second degree burn was sustained on her right upper thigh and subsequently became infected. The facility had implemented corrective action on 5/8/20, the deficient practice is being issued at harm level, past non-compliance. Finding include: R1's discharge return anticipated Minimum Data Set (MDS) dated 4/16/20, identified R1 had severe cognitive impairment and required total assistance from staff for activities of daily living (ADL's), transfers, bed mobility, dressing, toileting, personal hygiene, bathing and eating. R1's MDS did not identify her ability to communicate and indicated she had no skin issues. R1's quarterly MDS dated 1/3/20, identified R1 had diagnoses which included diabetes mellitus, cerebral ischemia (a blockage in an artery to the brain, resulting in damage to brain tissue), hemiplegia and hemiparesis affecting right dominate side and had severe cognitive	2 830	Corrected	

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2 830	Continued From page 9 impairment. The MDS indicated R1 was totally dependent on staff for ADL's of transfers, bed mobility, toileting, and dressing, did not eat and utilized a feeding tube for nutrition. The MDS did not identify R1's ability to communicate, and indicated R1 was at risk for pressure ulcers, and had no skin issues. R1's care plan, revised 5/8/20, revealed R1 had skin impairment of the right thigh related to rupture of fluid filled blister, altered respiratory status/difficulty breathing related to aspiration pneumonia and staff were to administer medication/puffers as ordered. The care plan indicated R1 required total assistance with transfers, repositioning, bed mobility, toileting, personal hygiene, had impaired communication and staff were to anticipate and meet her needs. On 5/15/20 at 3:01 p.m. registered nurse (RN)-A stated he had worked the evening shift on 4/30/20, and had entered R1's room at approximately 4:00 p.m. and found a nebulizer machine on her bed, immediately adjacent to her right thigh. RN-A stated the nebulizer machine was turned on and running on her bed next to R1's right thigh. He indicated R1 was totally dependent on staff for all of her needs and received daily nebulizer treatments. RN-A indicated he removed the nebulizer from R1's bed, placed the nebulizer on the floor and left the room. RN-A indicated later that evening an NA notified him R1 had blisters on her right thigh. RN-A confirmed he observed 2 small blisters on her right thigh and indicated he was unsure of what caused them or how long they had been there. RN-A indicated he got busy with another resident and did not notify the doctor or nurse manager, although he did report the incident to another nurse, LPN-C, at shift change.	2 830		

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2 830	Continued From page 10 On 5/18/19 at 10:22 a.m. during a telephone interview with LPN-B, he indicated on 4/30/20, at approximately 12 noon, he had administered R1's breathing medication via nebulizer, had placed a face mask on R1's face, turned on the machine and had left the room. LPN-B stated he got distracted with another resident and had not returned to R1's room. He stated R1 was totally dependent on staff for all ADL's and indicated she was non verbal and received daily nebulizer treatments. LPN-B indicated he did not remember having placed the nebulizer on R1's bed, next to R1's right thigh. LPN-B indicated on that day his routine "was messed up" and he could not recall if he had returned to R1's room to turn the nebulizer off. LPN-B stated the normal practice would be to stay with R1 when he administered her nebulized medication and indicated the nebulizer machine should be on the night stand while running, not on R1's bed. During observation on 5/18/20, at 11:27 a.m. R1 laid in bed on her back, covered with blankets and the head of her bed slightly elevated. At that time, licensed practical nurse (LPN)-A and nursing assistant (NA)-A entered R1's room. LPN-A uncovered R1's right side, and removed a soiled beige colored dressing, dated 5/15/20, from her thigh. The beige dressing had a scant amount of serosanguinous drainage noted on it. LPN-A measured R1's right thigh wound, which measured 6 cm x 4 cm wide, wound bed was dry, no drainage, pink in color with a few white spots in middle of wound bed, the outer edges were intact, dry and flaky. LPN-A proceeded to cleanse and apply a new dressing to R1's right thigh wound and proceeded to administer a nebulizer treatment to R1.	2 830		

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2 830	Continued From page 11 R1's Incident Report dated 5/4/20, identified R1 had a 7.5 centimeters (cm) long x 4.5 cm wide blister of unknown origin. The incident report identified R1's blister was located on her right anterior lateral thigh, had erythema (superficial reddening of the skin, as a result of injury or irritation) extending from the blister. The Incident Report had two smaller red areas at the posterior, medial aspect of the blister as well. R1's Order Summary Report dated 4/30/20, indicated an order for Ipratropium-Albuterol solution (medication used to open airways) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) one vial inhale orally four times a day for spasms of the lung air passages. The Order Summary Report did not address the use of a nebulizer for R1. R1's Progress Notes from 4/28/20 to 5/19/20, revealed the following: - 4/28/20, re-admitted from hospital, after sepsis secondary to aspiration pneumonia and urinary tract infection, lungs sounds clear, orientation could not be assessed due to vegetative state. New stage two pressure ulcer present to her sacrum, however, did not identify any other skin alterations. - 5/3/20, at 12:30 a.m. large blister noted to upper right thigh measured 7.5 cm in length by 4.5 cm wide, blister bubble was 1.5 cm high, surrounding tissue showed no signs or symptoms of infection. - 5/3/20, at 1:43 a.m. writer discussed blister with coworker who had worked R1's unit recently and coworker stated the nebulizer machine had been placed on bed while in use and the air/vibration of the machine agitated the skin, which caused a	2 830		

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2 830	Continued From page 12 blister. The coworker was unsure of when this event had occurred. The note revealed the author would follow up with staff in the morning for more clarification. - 5/4/20 at 4:31 p.m. physician progress note indicated she had been asked to evaluate R1 for the skin injury with blister to right thigh. The note indicated staff were unaware when the blister developed, but had been reported that day. A very large blister was present on her right anterior lateral thigh which measured 7.5 cm x 4.5 cm. There was erythema extending from the blister, but the area was not warm to touch and there was two small areas at the posterior, medial aspect of the blister. There had been unconfirmed reports a nebulizer was placed on R1's bed that fell on R1 and was possible source of injury. The area was suspicious for burn verses friction as the two areas to the posterior medial aspect could have come from the foot of the nebulizer machine. - 5/5/20, blister had no drainage, was covered with a Mepilex dressing (absorbent foam dressing). The note revealed staff would continue to monitor R1's blister. A later note at 1:45 p.m. indicated R1 was seen by her primary medical doctor (MD) via zoom regarding blister on posterior right thigh. Blister was now opened and draining, Mepilex dressing intact. - 5/7/20, seen by her primary MD via zoom regarding right thigh blister. The note revealed an order was given for Augmentin (antibiotic) tablet 875-125 milligrams (mg) for prophylactic for seven days twice a day. - 5/8/20, blister on right thigh had opened and had "turned into a wound."	2 830		

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2 830	Continued From page 13 - 5/11/20, wound assessment completed, no complaints of pain during assessment, incorrectly identified R1 had stage two non pressure related wound, to posterior right thigh which had improved dramatically from last week. The wound measurement 6.5 cm x 4.5 cm x 0 cm, with defined edges, brown/cream in color, warm upon palpation, no drainage noted, and no odor. R1 was currently on antibiotic prophylaxis and Mepilex dressing every third day and as needed. On 5/18/20 at 1:45 p.m. director of nursing (DON) reviewed R1's medical record and confirmed R1 had sustained a blister to her right thigh from a nebulizer being left running in her bed. The DON indicated she would expect staff to remain with R1 while she received her treatment, and the nebulizer machine to be placed on a flat surface like a table or night stand when the treatment was being administered. She indicated R1 required staff assistance with all her ADL's, and received nebulizer treatments routinely throughout each day. On 5/18/20 at 2:19 p.m. administrator confirmed R1 sustained a second degree burn to her right thigh because staff had left a nebulizer machine running on R1's bed. The administrator indicated she would expect staff to assess the resident wound after the incident, contact the doctor, DON and herself to report the incident when it first occurred. On 5/18/20 at 3:18 p.m. LPN-C stated R1 was totally dependent on staff, was unable to verbalize her needs or wishes and received daily nebulizer treatments. LPN-C stated on 4/30/20, RN-A had instructed her "not to leave [R1'] nebulizer machine on her bed," and had been told R1's	2 830		

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2 830	Continued From page 14	2 830		

nebulizer should be kept on the night stand during administration. LPN-C indicated on 4/30/20, RN-A was aware of R1's thigh injury and had taken LPN-C into the room to observe the area. LPN-C indicated she had not assessed R1's thigh wound or notified her primary physician or the DON and had been under the impression RN-A had done those things. LPN-C indicated normal practice was to assess the resident, stay with the resident when administering a nebulizer treatment and to make sure the nebulizer was placed on the night stand during administration.

On 5/18/20 at 3:40 p.m. during telephone interview with R1's medical doctor (MD)-A she had indicated staff notified her of R1's large skin lesion which measured 4 to 5 cm and blistered. MD-A indicated she had reviewed R1's recent hospital records and there had been no documentation of a skin lesion and she did not know how the blister had occurred. MD-A indicated the facility notified her of R1's blister on 5/4/20, and the facility had not told her the cause of the blister. MD-A indicated the wound was draining with no inflammation and she ordered dressing changes to wound. MD-A indicated she had seen R1 again on 5/7/20, and she thought the wound was infected and ordered Augmentin (antibiotic). MD-A indicated in her clinical opinion the heat from the nebulizer left on for hours could have caused this type of injury.

Review of the Aeromist Colors Nebulizer Compressor Kit Instructions Manual, undated, indicated under warnings: never block the air opening of the product or place it on a soft surface, such as bed or couch, when the air opening may be blocked. Under operating instructions: place compressor on a stable, sturdy and flat surface.

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2 830	Continued From page 15 Review of facility policy titled, Administering Medication Through A Small Volume (handheld) Nebulizer, reviewed on 5/8/20, indicated assemble equipment and supplies on the residents's over bed table, assemble nebulizer equipment and attach to the source of gas per manufactures instructions and remain with the resident for the treatment. Review of facility policy titled, Accidents And Incidents- Investigating And Reporting, updated on 6/9/19, indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The past non-compliance that began on 4/30/20, was verified during the 5/15/20, onsite visit and was corrected by the facility on 5/8/20. The verification of corrective action was confirmed by interview with a variety of nursing staff, residents and observation of residents who utilized nebulizer treatments, in addition to documentation of education provided to the nursing staff. On 5/8/20, the facility had retrained the licensed nursing staff on the Administration Medication Through a Small Volume Nebulizer policy, Accident and Incident-Investigating and Reporting policy, Weekly Skin Evaluation policy, Charting and Documentation policy, and notification of change protocol. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services and supervision to prevent injuries from occurring with the use of nebulizers. The director of nursing or designee,	2 830		

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2 830	Continued From page 16 could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 24 hours, to the State Agency (SA) an incident of neglect of care for 1 of 1 resident (R1) reviewed for neglect of care.	21990	Corrected	6/26/20

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21990	Continued From page 17 Findings include: R1's discharge return anticipated Minimum Data Set (MDS) dated 4/16/20, identified R1 had severe cognitive impairment and required total assistance from staff for for activities of daily living (ADL's) of transfers, bed mobility, dressing, toileting, personal hygiene, bathing and eating. R1's MDS did not identify her ability to communicate and indicated she had no skin issues. R1's quarterly MDS dated 1/3/20, identified R1 had diagnoses which included Diabetes Mellitus, cerebral ischemia (a blockage in an artery to the brain, resulting in damage to brain tissue) , hemiplegia and hemiparesis affecting right dominate side and had severe cognitive impairment. The MDS indicated R1 was totally dependent on staff for ADL's of transfers, bed mobility, toileting, and dressing, did not eat and utilized a feeding tube for nutrition. The MDS did not identify R1's ability to communicate, and indicated R1 was at risk for pressure ulcers, and had no skin issues. R1's care plan, revised 5/8/20, revealed R1 had skin impairment of the right thigh related to rupture of fluid filled blister, altered respiratory status/difficulty breathing related to aspiration pneumonia and staff were to administer medication/puffers as ordered. The care plan did not address the use of a nebulizer for R1. On 5/15/20 at 3:01 p.m. registered nurse (RN)-A stated he had worked the evening shift on 4/30/20, and had entered R1's room at approximately 4:00 p.m. and found a nebulizer machine on her bed, immediately adjacent to her right thigh. RN-A stated the nebulizer machine	21990		

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21990	Continued From page 18	21990		

was turned on and running on her bed next to R1's right thigh. He indicated R1 was totally dependent on staff for all of her needs and received daily nebulizer treatments. RN-A indicated he removed the nebulizer from R1's bed, placed the nebulizer on the floor and left the room. RN-A indicated later that evening an NA notified him R1 had blisters on her right thigh. RN-A confirmed he observed 2 small blisters on her right thigh and indicated he was unsure of what caused them or how long they had been there. RN-A indicated he got busy with another resident and did not notify the doctor or nurse manager, although he did report the incident to another nurse, LPN-C, at shift change.

R1's progress note dated 5/3/20, at 12:30 a.m. identified R1 had a large blister noted to upper right thigh measured 7.5 cm in length by 4.5 cm wide, blister bubble was 1.5 cm high, surrounding tissue showed no signs or symptoms of infection.

- a later note, at 1:43 a.m. writer discussed blister with coworker who had worked R1's unit recently and coworker stated the nebulizer machine had been placed on bed while in use and the air/vibration of the machine agitated the skin, which caused a blister. The coworker was unsure of when this event had occurred. The note revealed the author would follow up with staff in the morning for more clarification.

R1's Incident Report dated 5/4/20, identified R1 had a 7.5 centimeters (cm) long x 4.5 cm wide blister of unknown origin. The incident report identified R1's blister was located on her right anterior lateral thigh, had erythema (superficial reddening of the skin, as a result of injury or irritation) extending from the blister. The incident report had two smaller red areas at the

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21990	Continued From page 19 posterior, medial aspect of the blister as well. Review of the facility submitted SA report dated 5/4/20, at 4:08 p.m. identified R1 had sustained a blistered area with an unknown etiology. The report revealed the facility had begun an investigation. On 5/18/20 at 1:45 p.m. director of nursing (DON) reviewed R1's medical record and confirmed R1 had sustained a blister to her right thigh from a nebulizer being left running in her bed. The DON stated she had first been made aware of R1's blister during a routine record review following the previous weekend. The DON confirmed she had not been aware of R1's injury with blister prior to 5/4/20. The DON confirmed she had reported R1's blister of unknown etiology to that day. On 5/18/20 at 2:19 p.m. administrator confirmed R1 sustained a second degree burn to her right thigh because staff had left a nebulizer machine running on R1's bed. The administrator confirmed she had not been aware of R1's second degree burn until the DON had notified her on 5/4/20. The administrator stated she would expect staff to immediately have reported the incident to the DON and herself when the incident had occurred. Review of the facility policy titled, Abuse Investigations reviewed on 4/24/20, indicated should an incident or suspected incident of resident abuse, mistreatment, neglect, exploitation or mistreatment, including injuries of unknown source be reported to , the administrator , or his/her designee, will initiate OHFC stated report immediately but no later that 2 hours after the allegation was made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later that 24	21990		

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21990	Continued From page 20 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Any reasonable suspicion of crime is also to be reported to law enforcement within this time frame. SUGGESTED METHOD OF CORRECTION: The Adminstrator and/or designee could review the facility polices in regards to reporting of allegations of mistreatment and neglect of care to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. SUGGESTED TIME FOR CORRECTION: fourteen days (14)	21990		