



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 27, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 17, 2023
Event ID: NJIA12

Dear Administrator:

On October 3, 2023, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 17, 2023. (42 CFR 488.417 (b))

On October 17, 2023, the Minnesota Department of Health completed a revisit 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F0725 -- S/S: E -- 483.35(a)(1)(2) -- Sufficient Nursing Staff
20800 -- MN Rule 4658.0510 Subp. 1 -- Nursing Personnel; Staffing Requirements

As a result of the revisit findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(b), effective October 17, 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 October 17, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 17, 2023.

An equal opportunity employer.

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 October 27, 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 August 17, 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 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2024 (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
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact 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

The Terrace At Crystal LLC

October 27, 2023

Page 5

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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 17, 2023

Dear Administrator:

On October 27, 2023, we notified you a remedy was imposed. On December 19, 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 December 15, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 17, 2023 be discontinued as of December 15, 2023. (42 CFR 488.417 (b))

In our letter of , in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 17, 2023. 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, 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

December 20, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number NJIA13

Dear Administrator:

On December 4, 2023, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of \$300 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on November 28, 2023 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$300.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling \$69.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$369.60 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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.

Sincerely,

The Terrace At Crystal LLC

December 20, 2023

Page 2

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 28, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: April 18, 2023

Dear Administrator:

On April 26, 2023, we informed you that we may impose enforcement remedies.

On September 21, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2023.

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 July 18, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 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

The Terrace At Crystal LLC

September 28, 2023

Page 2

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 April 26, 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 July 18, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor

Metro 1, Golden Rule 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: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 18, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

The Terrace At Crystal LLC

September 28, 2023

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specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 28, 2023

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: NJIA11

Dear Administrator:

The above facility was surveyed on September 19, 2023 through September 21, 2023 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.

The Terrace At Crystal LLC

September 28, 2023

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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:

Annette Winters, Rapid Response Unit Supervisor

Metro 1, Golden Rule 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: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/21/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 9/19/23, 9/20/23 and 9/21/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

09/29/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/21/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed, H52895477C (MN96725 with a licensing order issued at 0800, 0900 and 3010. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/21/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide sufficient staffing to ensure resident care needs were provided for 4 of 4 residents (R1, R3, R4, R5 and R6) who expressed concerns of not being toileted timely and concerns with dependent residents not assisted with activities of daily living (ADL's) timely. Findings include: R3 - See F686. Resident Listing printed 9/19/23, indicated 33 of	2 800	Corrected	10/13/23

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2 800	Continued From page 3 72 resident resided on the third floor. And the facility listing of residents who require two staff assist for activities of daily living included 18 of 33 residents that reside on the third floor. R1's quarterly minimum data set (MDS) dated 7/27/23, indicated R1's cognition was intact and diagnoses of diabetes, anxiety disorder and depression. R1 required extensive assist of two staff with bed mobility, toileting, dressing and hygiene and transfers, walking and locomotion did not occur. R1 was frequently incontinent of bowel and bladder. R1's care plan, dated 5/27/22 indicated a focus of ADL self-care needs, interventions revised on 4/12/23, identify to check for toileting every 2 hours. R1's Device Activity Report, identified R1's average call light time response from 9/16/23 to 9/21/23 were 31 minutes and 22 seconds. Call light wait dates and times over 30 minutes: Saturday, 9/16/23: 10:04 a.m. to 10:41 a.m. for a total wait time of 36 minutes and 31 seconds 11:00 a.m. to 11:44 a.m. for a total wait time of 43 minutes and 18 seconds 11:55 a.m. to 12:38 p.m. for a total wait time of 42 minutes and 35 seconds 1:22 p.m. to 3:35 p.m. for a total wit time of 132 minutes and 59 seconds 6:50 p.m. to 11:16 p.m. for a total wait time of 265 minutes and 53 seconds Sunday 9/17/23: -3:49 am until 4:22 a.m. a total wait time of 33 minutes and 42 seconds -10:21 a.m. until 11:18 a.m. for a total wait time of	2 800		

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2 800	Continued From page 4 56 minutes and 41 seconds -2:42 p.m. until 3:23 p.m. for a total wait time of 41 minutes and 6 seconds -6:47 p.m. until 10:22 p.m. for a total wait time of 214 minutes and 42 seconds Monday 9/18/23: -6:39 a.m. until 10:39 a.m. for a total wait time of 250 minutes and 27 seconds. -2:58 p.m. until 4:14 p.m. for a total wait time of 76 minutes and 3 seconds. 10:56 p.m. until 11:37 p.m. for a total wait time of 41 minutes and 40 seconds Tuesday 9/19/23: -1:46 p.m. to 2:17 pm for a total wait time of 30 minutes and 48 seconds -2:47 p.m. to 4:14 p.m. for a total wait time of 87 minutes and 28 seconds -8:02 p.m. to 8:43 p.m. for a total wait time of 41 minutes and 35 seconds During an interview on 9/19/23, at 10:24 a.m. nursing assistant (NA)-D stated, the facility was very short staffed on this floor. There were lots of times where the staff went into resident's rooms and their call lights were on and the residents were soiled or wet themselves. NA-D stated there used to be four aides scheduled and now staff cannot get basic cares completed timely. NA-D stated the floor was a very heavy floor with lots of heavy cares, with two staff assist. R1 takes an hour to get washed up in the morning alone, other residents are very timely. There were about 20 residents out of the 33 residents that require two persons assist and they only schedule three aides. NA-D stated there was no way staff have time to get everyone up for the day timely then toilet and reposition everyone timely. NA-A stated staff need to be able to provide the	2 800		

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2 800	Continued From page 5 cares to residents, so they do not get pressure ulcers, or fall trying to get to the bathroom. During an interview on 9/19/23 at 10:39 a.m. R1 stated the call light times were unbelievably scary and long. "I have had my call light on now for 15 minutes." The call light response times have not gotten better, had to sat in bowel movement for extended periods of time due to not having the call light answered. "I have my cell phone and will call the front desk if I am really nervous, but what about the people here who don't have a cell phone? It needs to change; it is scary for us." R1 was given a bell to use but the staff must not hear it. The facility did not have enough staff to answer call lights and described that one time her blood sugar got down to the 50's and she had her call light on for over an hour, no one came, she used her phone, and called 911, and the paramedics would not leave until they were sure her blood sugar was back to normal. During an interview on 9/20/23, at 10:13 am, nursing assistant (NA)-C stated the call light system is not great, the only way staff know if a call light on is to look at the black digital boards hanging up and the end of each hall, there are four of them on third floor. It will make a short beep when it first comes on, but if you are in a resident room helping someone you would never hear it. NA-C stated staff have no way of knowing how long a call light was on because when you come out of a room and see three call lights going off staff have no way to know who has had their call light on the longest. NA-C stated she gets a lot of complaints from residents about long call light wait times. NA-C stated she was very frustrated when there is no continuous beeping, no pager system, just the digital boards that hang up on the hallway that does not run continuous.	2 800			

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2 800	Continued From page 6 NA-C stated you would have to look at it for a good minute to see if a call light is even on. NA-C stated the facility is short staffed, especially on Mondays, Thursdays, and Fridays, those are the days the facility does not have a wound nurse, so the floor nurse has to do all the wound treatments. R2's wound care takes at least an hour and a half to do. There were three aides scheduled for 33 residents, and well over half of residents are high acuity requiring a two person assist, we are not able to follow each resident's care plan to completed toileting and turning and repositioning timely due to the short staffing. R4's Medicare 5-day MDS dated 8/18/23, indicated R4's cognition was intact with diagnoses of cerebral palsy and acute and chronic respiratory failure with hypoxia. R4 required extensive assist of two staff with bed mobility, toileting, dressing, hygiene and transfers, walking did not occur. R4 was frequently incontinent of bowel. R4's care plan dated 4/20/23, identified a focus of ADL self-care performance deficit related to cerebral palsy, impaired balance, and limited mobility. Interventions revised on 5/31/23 indicated R4 was totally dependent on staff for turning and repositioning while in bed, toilet use and hygiene. During an interview on 9/20/23 at 10:54 a.m. R4 stated the call light times were horrible. R4 stated if there was a real emergency, a resident would be in trouble especially if they did not have a phone because sometimes it takes two or more hours to get her call light answered. R4 stated "Sometimes I wonder if my call light even works because it takes so long to get it answered. This happened to me over the weekend" when it took	2 800		

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2 800	Continued From page 7 staff over two hours for assistance while lying in bed soiled. R4 stated the facility seemed to be short staffed over the weekend. R4's Device Activity Report, identified R4 's average call light time response from 9/16/23 to 9/21/23 were 40 minutes and 27 seconds. Call light wait dates and times over 30 minutes: Saturday, 9/16/23: 6:47 p.m. to 9:59 p.m. for a total wait time of 191 minutes and 59 seconds 10:45 p.m. to 11:21 p.m. for a total wait time of 35 minutes and 50 seconds Sunday 9/17/23: -10:08 am until 4:32 p.m. a total wait time of 383 minutes and 25 seconds. -8:24 p.m. until 9:01 p.m. for a total wait time of 36 minutes and 30 seconds -9:39 p.m. until 10:24 p.m. for a total wait time of 40 minutes and 55 seconds Monday 9/18/23: -12:40 pm until 4:14 p.m. for a total wait time of 214 minutes and 30 seconds. -5:50 p.m. until 7:16 p.m. for a total wait time of 85 minutes and 57 seconds. Tuesday 9/19/23: -10:08 am to 12:25 p.m. for a total wait time of 137 minutes and 14 seconds -7:04 p.m. to 8:16 pm for a total wait time of 72 minutes and 40 seconds R5's quarterly MDS dated 7/21/23 indicated R5's cognition was moderately impaired with diagnoses of multiple sclerosis and spastic hemiplegia affecting the left dominant side. R5 required extensive assist of two staff with bed	2 800		

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2 800	Continued From page 8 mobility, toileting, dressing, hygiene, and total dependence of two staff with transfers, walking did not occur. R5 was always incontinent of bowel. R5's care plan dated 2/19/29 indicated a focus of an ADL self-care performance deficit related to multiple sclerosis and spastic hemiplegia, interventions revised on 4/11/19 indicated R5 required extensive assist of two staff for bed mobility and to turn and reposition every two hours and required assist of two staff and a mechanical lift for transfers. An additional focus dated 9/9/20, was resident preferences, usual wake time at 8:00 a.m. During an observation and interview on 9/20/23 at 10:25 a.m. At 10:32 a.m. R5 was weakly yelling, nurse! nurse! nurse, from room 303 bed 2. The call light indicator on the wall was lit up red, but the marquee did not identify that R5's light is on. R5 stated, "I need the nurse right away." At 10:33 a.m. NA-B was seated at the north nurse's station and stated he did not hear R5 yelling, NA-B looked at the marquee and stated it should be telling us if a light is on and it is not. NA-B walked in R5's room indicated the call light indicator box on the wall was red and went on to assist R5. At 10:34 a.m. licensed practical nurse (LPN)-A was noted to unplug the scrolling marquee on the northeast hall and wait a few seconds and plugged it back in. Room 302 bed 1 lit up as did room 303 bed 2. LPN-A stated, sometimes the board goes blank, staff unplug it to reset it, that is what the maintenance have done before when that happens, and it happens quite a bit. LPN-A was unable to articulate how staff are alerted when the marquee is not functional and needs a reboot.	2 800		

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2 800	Continued From page 9 R6's quarterly MDS dated 8/28/23, indicated R6 cognition was moderately impaired with diagnoses of diabetes mellitus, stroke with hemiplegia and aphasia. R6 required extensive assist of two staff with bed mobility, toileting, dressing, hygiene, and walking did not occur. R6 was frequently incontinent of bowel and bladder. R6s care plan dated, 10/11/19, indicated a focus of resident preferences, intervention revised on 10/15/19 indicated usual wake up time is 7:00 a.m., and to turn and reposition every two hours while in bed. R6's Device Activity Report, identified R6's average call light time response from 9/16/23 to 9/20/23 was 51 minutes and 0 seconds. Call light wait dates and times over 30 minutes: Sunday 9/17/23: -10:02 am until 11:57 a.m. a total wait time of 115 minutes and 32 seconds. Monday 9/18/23: -8:49 am until 3:48 p.m. for a total wait time of 418 minutes and 52 seconds. -9:37 p.m. until 10:24 p.m. for a total wait time of 85 minutes and 57 seconds. Tuesday 9/19/23: -10:35 am to 11:59 a.m. for a total wait time of 83 minutes and 44 seconds Wednesday 9/20/23: -10:14 am to 11:11 a.m. for a total wait time of 56 minutes and 25 seconds During a continuous observation on 9/20/23 at 10:25 a.m. to 11:11 a.m. R6 was noted to be lying in bed with a facility gown on, R6 was unable to	2 800		

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2 800	Continued From page 10 speak, and the call light was on. NA-A went into R6's room and shut the call light off and then went into R5's room with the Hoyer lift. During an interview on 9/20/23, at 12:47 p.m. NA-A stated due to short staffing, there is not time to get everyone up per their care plan in the morning, and no time to toilet and reposition everyone that needs it. There are 20 residents that require two persons assist. R5 and R6 require two staff and were not gotten out of bed until after 11:00 am, staff did not have time to lay R3 down after breakfast. R5 usually likes to be up by 8:00 a.m. NA-A stated staff do their best, the facility needs more staff on the floor, and there are no times for breaks. During an interview on 9/20/23 at 12:52 p.m. NA-B verified R5 and R6 did not get washed up, dressed and out of bed until after 11:00 a.m. NA-B stated they should have been out of bed before breakfast and was due to not having enough staff on the floor to provide cares to everyone. During an interview on 9/20/23 at 2:14 p.m. the DON indicated the way the call light system is set up there is no way for the aides to know if a call light goes on when they are assisting in resident rooms and they have no idea how long a light has been on, because it's on the black box at the end of each hall. The call light times are not acceptable as the facility was reviewing the audits. It is not safe, if a resident had a real emergency, like having chest pain or something, and they waited an hour to get their call light answered it may be too late. The DON stated if the facility could get the pager system hooked up, then at least staff would be alerted to when a resident turns their call light on. Call lights should	2 800		

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2 800	Continued From page 11 be answered within 10 minutes. The DON stated staffing has been a problem because the facility cut 17 staff and staffing is not based on acuity. The short staffing concern was brought forward to the owner, and he has not given the ok to staff any differently. During an interview on 9/21/23, at 12:48 p.m. administrator stated the facility continues to have call light problems, through the audits they are still too long. Using the Stanley Aerial wireless call light system, the lights above the resident doors are inoperable, and would have to be hard wired for them to work, which is not in the budget. The owner wanted maintenance to hook up the pager systems, but the facility does not have the manufacturer instructions to do so. The facility received a quote from Securitas Healthcare on 6/28/23, to have the pagers hooked up, the quote was \$2,392.50. The administrator stated the owner did not budget for that. The call light system we have in place should light up on the boards at the end of each hall and at the nurse's stations, they are only audible when a resident first puts their call light on. The boards should be running continuously until the call light is deactivated. The facility does not do any routine maintenance on the call light system, but the maintenance department does audit once a month to ensure they are working. Staffing has been a problem, they cut 17 staff and staffing is not based on acuity, the short staffing concerns have been brought forward to the owner and he has not given the ok to staff any differently. For third floor to be sufficiently staffed, to ensure all residents basic needs are met, there should be two nurses and four aides on day and evening shift, there are 18 of 33 residents that require extensive assist of two staff with ADLs, which is why the facility needs four aides on to be staffing	2 800		

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2 800	Continued From page 12 for acuity. During an interview on 9/21/23, at 3:33 p.m. the facility owner (FO) indicated an unawareness of call light malfunctions, long call waits times, and short staffing. FO was unable to articulate how he has tried to help the facility fix these issues. Facility staff schedule dated 9/18/23, 9/19/23, and 9/20/23, indicated for the day shift that one nurse, one trained medication aide (TMA), and three NAs worked the day shift, two nurses and three NAs worked the evening shift, and one nurse and two NAs worked the night shift. Facility assessment dated 7/28/23, indicated section 1.4 Acuity, indicated 300 Wing- Long Term Residents - The unit is prepared to appropriately care for residents that have complex wounds, complex medication regimes, multiple therapeutic treatments and IV therapy needs. Section 3.3 Individual staff assignment indicated consistent Assignment, we determine and review individual staff assignments for coordination and continuity of care for residents within and across staff assignments. We evaluate census and acuity when determining staffing levels necessary to provide appropriate care. A facility policy titled Answering the Call Light dated 11/2022, indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs. In addition, the policy indicated there was a call light above the room door. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident	2 800			

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2 800	Continued From page 13 population to staffing availability so residents received safe, adequate and timely assistance with toileting, repositioning, and pressure ulcer care. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced	2 900		10/13/23

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2 900	Continued From page 14 by: Based on observation, interview, and document review, the facility failed to perform timely comprehensive skin assessments, follow provider orders for therapy to assess for necessary equipment, provide interventions, monitoring, and care for pressure ulcer prevention, management and treatment who was admitted to the facility without pressure ulcers for 1 of 3 residents (R3) reviewed for pressure ulcers R3 was harmed when the facility failed to develop and implement interventions to promote healing and prevention resulting in R3 developing an unstageable pressure ulcer. Findings include: According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 211, 02-03-23 an Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss is full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.	2 900	Corrected	

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2 900	Continued From page 15 R3's annual minimum data set (MDS), dated 5/5/23, indicated R3 had severe cognitive impairment, had diagnoses of multiple sclerosis (MS) an autoimmune disease that affects the brain and spinal cord resulting in fatigue, numbness/tingling, muscle spasms, stiffness, and pain, Peripheral Vascular Disease (PVD) the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel, elevating your legs above heart level to keep blood from pooling in them can be beneficial to promote wound healing, and impaired gait and immobility. R3 required extensive assist of two staff with bed mobility, dressing, hygiene, and toilet use and was a total assist of two staff with transfers. R3 was at risk for pressure ulcers but did not identify any. R3's identify care area assessment (CAA) for pressure ulcers dated 5/19/23, indicated R3's extrinsic risk factors indicate pressure-needed a special mattress or seat cushion to reduce or relieve pressure. Intrinsic risk factors were immobility, altered mental status, cognitive loss, and incontinence. Pressure ulcer functional status would be addressed in the care plan. R3's care plan indicated a focus of (PVD), dated 5/22/23, with interventions to elevate legs when sitting or sleeping. An additional focus, dated 2/13/20, indicated R3 has a risk of injury to skin integrity related to PVD, immobility and history of contractures, with interventions dated 5/22/23, to provide a pressure relieving cushion while up in his chair, to provide a pressure relieving mattress to protect his skin while in bed and needed assist to provide bilateral foam boots. The care plan lacked interventions to have therapy assess for a new wheelchair and new wheelchair cushion, also lacked the order to lay down after meals	2 900		

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2 900	Continued From page 16 (breakfast and lunch) for at least 90 minutes. R3's integrated wound care note, dated 6/13/23, indicated R3 was being seen for evaluation and treatment recommendation for a pressure ulcer to the right posterior (back) inferior (low) thigh. Physical exam indicated an unstageable pressure ulcer with a moderate amount of serosanguinous (combination of blood and serous fluid) drainage with 90% slough and 10% granulation (the appearance of the red, bumpy tissue in the wound bed as the wound heals) tissue measuring 2.5 centimeters (cm) (length) x 1.5 cm (width) x 0.1 cm (depth) with a total circumference area of 3.75 cm. Treatment recommendations to cleanse with Vashe (a saline based wound cleanser that contains hypochlorous acid as a preservative that inhibits microbial contamination within the solution); apply Santyl (an ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal), cover with silicone border dressing to change daily and prn (as needed). Implement facility pressure ulcer prevention protocol, pressure redistribution mattress, incontinence care prn and optimize nutrition. Plan of care discussed with facility staff. R3's Treatment Administration Record (TAR) dated June 2023, indicated R3's right posterior inferior thigh pressure ulcer wound treatment order was not implemented until 6/17/23, indicating R3 missed three days of dressing changes from 6/14/23 to 6/16/23. R3's progress note dated 6/19/23, indicated a Braden Scale, a skin risk assessment for predicting pressure sore risk, was completed with a score of 13, indicating R3 was at moderate risk for skin breakdown.	2 900		

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2 900	Continued From page 17 R3's record was reviewed from 5/1/23 to 9/20/23 and no identification of when or how the unstageable pressure ulcer was first found, however the wound clinic saw R3 on 6/13/23. The medical record does not indicate if R3's pressure ulcer wound was reassessed or if a provider was notified of the missed dressing changes. Further, there was no indication a comprehensive wound assessment was completed for 14 days, between 6/13/23 and 6/27/23. R3's integrated wound care note, dated 6/28/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was deteriorating with 80% soft moist necrotic tissue (dead tissue), 15% adherent slough (nonviable tissue) and 5% granulation tissue with a small to moderate amount of serosanguinous drainage measuring 3.3 cm x 1.2 cm x 0.2 cm total circumference of 3.96 cm. Autolytic (using chemical enzymes to debride)-chemical (Vashe), enzymatic (Santyl), and mechanical debridement performed with cares. Treatment recommendations are to cleanse with Vashe, pat dry, apply skin prep to periphery, apply nickel thin amount of Santyl to non-intact area only; cover with 1 -2 layers of xeroform (non-adherent primary dressing maintains a moist wound environment to promote wound healing), secure with gauze border dressing. New Order to modify cushion of wheelchair due to pressure ridge against wound, plan of care discussed with staff. R3's integrated wound care note, dated 7/5/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound	2 900			

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2 900	Continued From page 18 was improving with 60% eschar and 40% slough with a moderate amount of serosanguinous drainage measuring 2.5 cm x 1.8 cm total circumference of 4.5 cm. Autolytic chemical (Vashe), enzymatic (Santyl), and mechanical debridement performed with cares. Treatment recommendations are to cleanse with Vashe; apply Santyl; calcium alginate-no silver (turns into a gel as they come in contact with wound exudate to provide a moist wound environment that facilitates autolytic debridement); and cover with silicone border dressing. New Order to lay down in bed after breakfast and lunch for at least 90 minutes daily and modify cushion of wheelchair due to pressure ridge against wound. Plan of care to consult therapy for proper chair fitting and discussed with facility staff. R3's integrated wound note dated 7/11/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 60% eschar and 40% slough with a moderate amount of serosanguinous drainage measuring 3.5 cm x 1.5 cm x 0.3 cm, total circumference of 5.25 cm. Treatment recommendations are no new changes to dressing. Reiterated to have [R3] lay down in bed after breakfast and lunch for at least 90 minutes daily and modify cushion of wheelchair due to pressure ridge against wound. Plan of care to consult therapy for proper chair fitting and discussed with facility staff. R3's Order Summary, dated 7/14/23, to turn and reposition every two to three hours, float heels off bed. R3's integrated wound care note dated 7/18/23, indicated R3's unstageable pressure ulcer to right	2 900		

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2 900	Continued From page 19 posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 60% slough and 40% granulation with a moderate amount of purulent drainage (a thick, milky white discharge indicating an unhealthy wound or infection that requires immediate attention) measuring 3.5 cm x 2.5 cm x 0.5 cm, total circumference of 8.75 cm. R3's pressure ulcer also indicated undermining at 11:00 to 1:00 measuring 1.6 cm. Treatment recommendations are no new changes to dressing. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care discussed with facility staff. R3's TAR, dated July 2023, indicated R3's pressure ulcer dressing was not changed on 7/15/23 and 7/31/23 indicated by a blank space where the signature of the nurse who performed the dressing change under those dates. Further indicated there was a new order on 7/14/23, for R3 to be turned and repositioned every two to three hours, there were several hours where this was not completed for R3 on the following days: 7/15/23, 7/19/23, 7/20/23, 7/21/23, 7/22/23, 7/24/23, 7/26/23, 7/27/23 and 7/31/23, the spaces provided were left blank. R3's record lacked wound assessments for 13 days, between 7/18/23 and 8/1/23. R3's quarterly MDS, dated 8/1/23, indicated R3 was at risk for pressure ulcers, and had an unstageable pressure ulcer that was not present upon admission, which required a pressure ulcer device for bed, pressure ulcer care and applications of ointments/medications other than to feet. R3's MDS lacked a pressure reducing device for R3's chair and lacked a turning and	2 900		

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2 900	Continued From page 20 repositioning program for pressure ulcer prevention. Last identified physical therapy (PT) services were 3/23/21 to 5/5/21. R3's Braden Scale for Predicting Pressure Sore Risk Assessment dated 8/1/23, indicated a score of 14 indicating R3 was at moderate risk for skin breakdown. Further indicated R3 was completely limited with ability to respond to meaningfully pressure related discomfort, skin is often, but not always moist, ability to walk is severely limited or non-existent, cannot bear own weight and/or must be assisted into own chair or bed, very limited ability to change and control body position, can make occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. R3's integrated wound care note dated 8/1/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 60% granulation and 40% slough with a moderate amount of purulent drainage measuring 3.5 cm x 2 cm x 0.3 cm, total circumference measured 7 cm. R3's pressure ulcer also indicated undermining at 11:00 to 1:00 measuring 1.5 cm. Treatment recommendations are no new changes to dressing. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs treatment evaluation for wheelchair fitting and discussed with facility staff. R3's integrated wound care note dated 8/8/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 90% granulation and 10%	2 900		

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2 900	Continued From page 21 slough with a moderate amount of serosanguinous drainage measuring 3.6 cm x 2.5 cm x 0.3 cm, total circumference measured 9 cm. R3's pressure ulcer also indicated undermining at 11:00 to 1:00 measuring 1.0 cm. Treatment recommendations are no new dressing changes to dressing. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs PT evaluation for new wheelchair fitting and seat cushion and discussed with facility staff. R3's TAR, dated August 2023, indicated R3's pressure ulcer dressing was not changed on 8/19/23, indicated by a blank space where the signature of the nurse who performed the dressing change should be under that date. R3 was to be turned and repositioned every two to three hours, there were several hours where this was not completed for R3 on the following days: 8/7/23, 8/8/23, 8/9/23, 8/12/23, 8/13/23, 8/19/23, 8/23/23, 8/28/23, 8/30/23 and 8/31/23, the spaces provided were left blank. R3's record lacked comprehensive wound assessments for 19 days from 8/9/23 to 8/28/23. R3's integrated wound care note dated 8/28/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 3.0 cm x 1.6 cm x 0.2 cm, total circumference measured 4.8 cm. No indication of undermining. Treatment recommendations are no new dressing changes ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new	2 900		

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2 900	Continued From page 22 wheelchair and wheelchair cushion. Plan of care-needs PT evaluation for new wheelchair and seat cushion and discussed with facility staff. R3's integrated wound care note dated 9/5/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 2.5 cm x 2.0 cm x 0.1 cm, total circumference measured 5.0 cm. Treatment recommendations are no new dressing changes ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs PT evaluation for new wheelchair and seat cushion and discussed with facility staff. R3's active Order Summary, dated 9/7/23, Needs PT eval for new wheelchair and seat cushion. Pressure relief/offloading, pressure ulcer prevention protocol to include pressure redistribution mattress, heel offloading and turn and repositioning. R3's integrated wound care note dated 9/12/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 1.8 cm x 1.5 cm x 0.1 cm, total circumference measured 2.7 cm. Treatment recommendations are no new dressing changes ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care- discussed with facility staff.	2 900			

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2 900	Continued From page 23 R3's integrated wound care note dated 9/19/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 2.5 cm x 1.5 cm x 0.1 cm, total circumference measured 3.75 cm. Treatment recommendations are no new dressing change ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care- discussed with facility staff. R3's TAR, dated September 2023, indicated R3 was to be turned and repositioned every two to three hours, there were several hours where this was not completed for R3 on the following days: 9/4/23, 9/7/23, 9/11/23, and 9/18/23 the spaces provided were left blank. During an observation on 9/19/23, at 3:12 p.m. R3 was seated in a Tilt-In Space wheelchair watching television in his room, R3's right and left thigh are resting at the lip of R3's wheelchair cushion with both feet dangling, nothing to rest the feet on to remove pressure from the thigh area. During an observation on 9/20/23, at 10:49 a.m. R3 was seated in a Tilt-In Space wheelchair watching television in his room, R3's right and left thigh are resting at the lip of R3's wheelchair cushion with both feet dangling, nothing to rest the feet on to remove pressure from the thigh area. During an observation on 9/20/23, at 1:42 p.m. PT-A pulled back the dressing affixed to R3's right posterior inferior thigh, wound bed was red	2 900			

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2 900	Continued From page 24 and bumpy indicating granulation tissue with a small amount of slough, cream colored tissue around the edges of the wound bed. No redness surrounding the wound, the dressing had a small amount of serosanguinous drainage noted. During an observation and interview on 9/20/23, at 12:47 p.m. R3 was seated in wheelchair in the dining room and had just finished eating his lunch, nursing assistant (NA)-A started wheeling R3 down the hall to his room and positioned R3 in front of his television next to his bed, R3's feet continue to have no support to offload pressure to thigh area. NA-A stated she got R3 out of bed and into his wheelchair at 7:30 a.m. NA-A stated we do not have enough staff on this floor to get R3 laid down after breakfast, we do not even get everyone up and out of bed today until almost 11:00 a.m. NA-A verified R3 had not been repositioned for over five hours and stated an awareness of R3 having a pressure ulcer behind the right knee, that R3 should be repositioned and offloaded every 2 hours for prevention of worsening of pressure ulcers. NA-A stated she worked at the facility for over twenty years. R3 always had the same wheelchair and wheelchair cushion, it had not been replaced. During an interview on 9/20/23, at 12:52 p.m. nursing assistant (NA)-B stated he had worked at the facility for a couple of years and had never noticed R3 to have a new wheelchair or wheelchair cushion. NA-B was aware that R3 had a pressure ulcer and stated they did not have time to lay R3 down after breakfast to offload or reposition as they were still getting other residents out of bed and ready for the day. NA-B stated all residents who are at risk for pressure ulcers or have pressure ulcers need to be repositioned every two hours.	2 900			

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2 900	Continued From page 25 During an interview on 9/20/23, at 1:17 p.m. director of therapy services, (DOTS)-A stated an unawareness of R3 having an unstageable pressure ulcer or any provider order for therapy to assess R3 for a new wheelchair or wheelchair cushion. DOTS-A stated she just became the director in July, there was no bridge program from the last director to me. If the provider from the wound clinic had orders for therapy to assess, the nurse rounding with the provider would put the orders in the medical record and therapy would assess and evaluate in the same day, then therapy would write out recommendations on a communication from and give one to the floor nurse, one to the nurse manager, and one to the director of nursing (DON). During an observation and interview on 9/20/23, at 1:28 p.m. physical therapist (PT)-A stated he was not aware R3 had an unstageable pressure ulcer and was not aware of any provider order to assess R3 for a new wheelchair and wheelchair cushion. PT-A and DOTS-A walked to R3's room, where R3 was lying in bed. PT-A stated that [R3] had a Tilt-In Space wheelchair, and it looked like there was a specialized formed cushion for positioning in [R3's] seat. [R3] should have support on his feet otherwise all the pressure is on [R3's] thigh, right where his pressure ulcer was. PT-A stated because his feet were dangling it caused the pressure in the thigh area and the pressure was preventable. PT-A stated turning and repositioning recommendation to nursing every two hours will help until therapy could get [R3] evaluated and assessed. DOTS-A stated the cause of R3's pressure ulcer to the back of his thigh is from his wheelchair causing his legs to dangle cutting off blood supply. PT-A pulled back the dressing on the back of R3's thigh and stated	2 900			

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2 900	Continued From page 26 the wound is 90% granulation and 10% slough, a stage 3 pressure ulcer. The DOTS-A stated therapy would have to order pressure mapping to determine high pressure areas to ensure [R3] gets the best wheelchair and cushion to prevent pressure to this thigh area and to help ensure healing. DOTS-A stated this should have been done right away when it was ordered in July. PT-A stated the best way to prevent pressure ulcers is by changing a person's lying or sitting position by turning and repositioning frequently, especially for R3 who was dependent on staff for mobility. During an interview on 9/20/23, at 1:54 p.m. licensed practical nurse (LPN)-A stated he was the nurse that rounds with the nurse practitioners every Tuesday and Wednesday and would be the nurse responsible to ensure new wound orders get put in the computer. LPN-A verified that the provider on 6/28/23, ordered for R3 to modify cushion of wheelchair due to pressure ridge against his pressure ulcer. And, further verified that every weekly wound note to current date addressed that R3 needed to be assessed by therapy to have a new wheelchair and wheelchair cushion to prevent pressure to his existing pressure wound and was not aware that therapy has not yet completed it. LPN-A was unable to articulate or show documentation of how therapy was notified of this order. During an interview on 9/20/23, at 2:14 p.m. the DON verified R3's provider order for therapy to evaluate and assess the need for a new wheelchair and wheelchair cushion to help offload pressure to existing pressure ulcer was not completed. The DON stated with a new order for therapy, the order should be placed in therapy's mailbox and therapy will assess and evaluate,	2 900			

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2 900	Continued From page 27 also the nurse is responsible for inputting the order in the computer, where therapy would see it. The DON stated his expectation is that [R3] should have been repositioned every two hours per the provider orders to help prevent pressure ulcers. The DON stated if a wound dressing change is left blank on the TAR, and there was no progress note indicating the dressing change was completed that the dressing change was not performed. All wound dressing orders would be performed as ordered. The DON stated R3's wheelchair appeared to be the cause of the unstageable pressure ulcer to the back of R3's right thigh. During an interview on 9/20/23, at 2:36 p.m. the administrator stated when a provider gives orders for a therapy evaluation it needs to be done immediately. The administrator confirmed that R3's order for therapy to evaluate and assess for a new wheelchair and cushion for pressure ulcer prevention were not performed when ordered on 6/28/23 and should have been. The administrator stated facility protocol is that residents should be repositioned every two hours when they have pressure ulcers. Facility policy, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated June 2022, Assessment and Recognition included the facility responsibility of: Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because	2 900		

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2 900	Continued From page 28 of other factors which cannot be modified. b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be	23010		10/13/23

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23010	Continued From page 29 connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light system was set-up in a functional manner to allow residents to call for staff assistance through a communication system which relays the calls directly to the staff member or a centralized work area. This had the potential to affect all 72 residents who resided within the facility. Findings include: During an observation on 9/19/23, at 8:41 a.m. on the third floor there were electronic call light display boxes (black rectangular shaped box with red colored electronic display) at the end of each hallway and one in front of the south nurses' station for a total of five boxes. There was not a box in front of the north nurse's station desk, if someone were sitting at this nurse's station they	23010	Corrected	

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23010	Continued From page 30 would have to get up and walk to their left or right to see the call light display boxes at the ends of the northeast and northwest hall. The display boxes displayed the room number pressed and the display identified which bed in the room needs assistance, the information continually scrolled across the box until service was no longer needed. No other information was displayed on the screen. Each resident room had a white light fixture above their door that was inoperable. During an interview on 9/19/23, at 8:59 a.m. with nurse manager (NM)-A was unsure whether the call light problem the facility had was fixed or not. NM-A stated there are scrolling marquees at the end of every hallway and total of 4 different ones at the ends of the north and south halls on this floor. NM-A pointed up to the end of the southwest hall that had a scrolling marquee and indicated that was what alerted staff that a call light was on. The scrolling marquee should be on continuously until the residents call light is answered. The system is not audible except when the light first is engaged, you will hear a light, quick, beep. If staff were in other resident rooms, you would be unable to hear it. The marquee does not tell you which resident put their call light on first or how long the call light was on. NM-A stated if there are three call lights are on, staff answer the light closest to us because they do not know who had their call light on first. The lights above the resident doors do not light up when the call light is engaged, and the staff do not have a pager to carry with them to alert them to when a call light goes on. NM-A stated, the facility might have the pagers now, but they have not hooked them up yet. During an interview on 9/19/23, at 10:39 a.m. R1 stated the call light times are unbelievably scary	23010		

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23010	Continued From page 31 and long. "I have had my call light on now for 15 minutes. The call light response times have not gotten better for us, I have sat in my own bowel movement for extended periods of time due to not having my call light answered, I have my cell phone and will call the front desk if I am really nervous, but what about the people here who don't have a cell phone? It needs to change; it is scary for us. They gave me a bell to use but they must not hear that either." During an interview on 9/20/23, at 10:13 am, nursing assistant (NA)-C stated, the call light system here is not great, the only way to know a call light's on is to look at the black digital boards hanging up and the end of each hall, there are four of them up here on third floor. It will make a short beep when it first comes on, but if you are in a resident room helping someone you would never hear it. Staff would have no way of knowing how long a call light has been on. if you come out of a room and see three call lights going off you have no way to know who has had theirs on the longest. Staff get lots of complaints from residents about long call light wait times. It is very frustrating for us, there is no continuous beeping, no pager system, just the digital boards that hang up on the hallway, and it does not run continuous so you would have to look at it for a good minute to see if a call light is even on. During an observation and interview on 9/20/23, at 10:25 a.m. the scrolling marquee at the end of the northeast hall indicated two call lights were on: room 312 bed 1 and Room 302 bed 1, there is nothing audible to alert staff that these lights are on. At 10:28 a.m. both lights go off on the marquee, but the light on the call light box on the wall of 302 bed 1 is lit up red. At 10:32 a.m. R7 weakly yelling, nurse! nurse! nurse, from room	23010			

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23010	Continued From page 32 303 bed 2. The call light indicator on the wall is lit up red, but the marquee does not identify that R7's light is on. R7 stated, "I need the nurse right away." At 10:33 a.m. NA-B was seated at the north nurse's station and stated he did not hear R7 yelling, NA-B looked at the marquee and stated it should be telling us if a light is on and it is not. NA-B walked in R7's room indicated the call light indicator box on the wall was red and went on to assist R7. At 10:34 a.m. licensed practical nurse (LPN)-A was noted to unplug the scrolling marquee on the northeast hall and wait a few seconds and plugged it back in. Room 302 bed 1 lit up as did room 303 bed 2. LPN-A stated, sometimes the board goes blank, staff unplug it to reset it, that is what the maintenance do here before when that happens. It happens quite a bit. LPN-A was unable to articulate how staff are alerted when the marquee is not functional and needs a reboot. During an interview on 9/20/23, at 10:54 a.m. R6 stated, the call light times here are horrible if you had a real emergency, you would be in trouble if you did not have a phone because sometimes it takes two or more hours to get your call light answered. "Sometimes I wonder if my call light even works because it takes so long to get it answered. This happened to me over the weekend." During an interview on 9/20/23 at 2:14 p.m. DON indicated the way the call light system is set up there is no way for the aides to know if a call light goes on when they are assisting in resident rooms and they have no idea how long a light has been on, it's the black box at the end of each hall. The call light times are not acceptable as the facility was reviewing the audits. It is not safe, if a resident had a real emergency, like having chest	23010		

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23010	Continued From page 33 pain or something, and they waited an hour to get their call light answered it may be too late. If the facility could get the pager system hooked up, then at least staff would be alerted to when a resident turns their call light on. Call lights should be answered within 10 minutes. During an interview on 9/21/23, at 12:48 p.m. administrator stated, the facility continues to have call light problems, through the audits they are still too long. Using the Stanley Aerial wireless call light system, the lights above the resident doors are inoperable, and would have to be hard wired for them to work, which is not in the budget. The owner wanted maintenance to hook up the pager systems, but the facility does not have the manufacturer instructions to do so. The facility received a quote from Securitas Healthcare on 6/28/23, to have the pagers hooked up, the quote was \$2,392.50. The administrator stated the owner did not budget for that. The call light system we have in place should light up on the boards at the end of each hall and at the nurse's stations, they are only audible when a resident first puts their call light on. The boards should be running continuously until the call light is deactivated. The facility does not do any routine maintenance on the call light system, but the maintenance department does audits once a month to ensure they are working. A facility policy titled Answering the Call Light dated 11/2022, indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs. In addition, the policy indicated there was a call light above the room door. The facility manufacturing instructions for the call light system was requested and none was	23010		

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23010	Continued From page 34 provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	23010			

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F 000	INITIAL COMMENTS On 9/19/23, 9/20/23 and 9/21/23, 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 complaint was reviewed, H52895477C (MN96725) with deficiencies issued at F686, F725, and F919. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		10/13/23	

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

Electronically Signed

TITLE

(X6) DATE

09/29/2023

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 686	Continued From page 1 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform timely comprehensive skin assessments, follow provider orders for therapy to assess for necessary equipment, provide interventions, monitoring, and care for pressure ulcer prevention, management and treatment who was admitted to the facility without pressure ulcers for 1 of 3 residents (R3) reviewed for pressure ulcers R3 was harmed when the facility failed to develop and implement interventions to promote healing and prevention resulting in R3 developing an unstageable pressure ulcer. Findings include: According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 211, 02-03-23 an Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss is full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not	F 686	1. R3 had a completed comprehensive skin assessment, physician orders have been followed up on for therapy to assess for necessary equipment, provide interventions, monitoring and care for pressure ulcer prevention, management and treatment. 2. All residents have the potential to be affected by this deficient practice, so a review was completed on residents with wounds to ensure a comprehensive assessment was completed weekly. Each resident will be reviewed to ensure they have necessary equipment, interventions and monitoring for the prevention, management, and treatment of pressure ulcers. A review will be completed for each resident to ensure there are not any physician orders that have not been followed through on. 3. A plan has been developed to ensure that physician orders are acted upon in a timely manner. A review process has been developed to ensure the comprehensive skin assessments are completed in a timely manner. The nurses and health unit coordinators have been educated in both areas to ensure the comprehensive skin assessments are completed in a timely manner and physicians orders are acted upon in a timely manner. 4. DON or designee will audit comprehensive skin assessments and physician orders 1x/week for one month,		

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F 686	Continued From page 2 have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. R3's annual minimum data set (MDS), dated 5/5/23, indicated R3 had severe cognitive impairment, had diagnoses of multiple sclerosis (MS) an autoimmune disease that affects the brain and spinal cord resulting in fatigue, numbness/tingling, muscle spasms, stiffness, and pain, Peripheral Vascular Disease (PVD) the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel, elevating your legs above heart level to keep blood from pooling in them can be beneficial to promote wound healing, and impaired gait and immobility. R3 required extensive assist of two staff with bed mobility, dressing, hygiene, and toilet use and was a total assist of two staff with transfers. R3 was at risk for pressure ulcers but did not identify any. R3's identify care area assessment (CAA) for pressure ulcers dated 5/19/23, indicated R3's extrinsic risk factors indicate pressure-needed a special mattress or seat cushion to reduce or relieve pressure. Intrinsic risk factors were immobility, altered mental status, cognitive loss, and incontinence. Pressure ulcer functional status would be addressed in the care plan. R3's care plan indicated a focus of (PVD), dated 5/22/23, with interventions to elevate legs when sitting or sleeping. An additional focus, dated 2/13/20, indicated R3 has a risk of injury to skin integrity related to PVD, immobility and history of contractures, with interventions dated 5/22/23, to provide a pressure relieving cushion while up in his chair, to provide a pressure relieving mattress	F 686	then every 2 weeks for one month, then monthly for 3 months. All audits will be brought to QAPI to assess for compliance and continued need for audits. 5. DON or designee will be responsible for the completion of this plan of correction.		

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F 686	Continued From page 3 to protect his skin while in bed and needed assist to provide bilateral foam boots. The care plan lacked interventions to have therapy assess for a new wheelchair and new wheelchair cushion, also lacked the order to lay down after meals (breakfast and lunch) for at least 90 minutes. R3's integrated wound care note, dated 6/13/23, indicated R3 was being seen for evaluation and treatment recommendation for a pressure ulcer to the right posterior (back) inferior (low) thigh. Physical exam indicated an unstageable pressure ulcer with a moderate amount of serosanguinous (combination of blood and serous fluid) drainage with 90% slough and 10% granulation (the appearance of the red, bumpy tissue in the wound bed as the wound heals) tissue measuring 2.5 centimeters (cm) (length) x 1.5 cm (width) x 0.1 cm (depth) with a total circumference area of 3.75 cm. Treatment recommendations to cleanse with Vashe (a saline based wound cleanser that contains hypochlorous acid as a preservative that inhibits microbial contamination within the solution); apply Santyl (an ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal), cover with silicone border dressing to change daily and prn (as needed). Implement facility pressure ulcer prevention protocol, pressure redistribution mattress, incontinence care prn and optimize nutrition. Plan of care discussed with facility staff. R3's Treatment Administration Record (TAR) dated June 2023, indicated R3's right posterior inferior thigh pressure ulcer wound treatment order was not implemented until 6/17/23, indicating R3 missed three days of dressing changes from 6/14/23 to 6/16/23.	F 686			

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F 686	Continued From page 4 R3's progress note dated 6/19/23, indicated a Braden Scale, a skin risk assessment for predicting pressure sore risk, was completed with a score of 13, indicating R3 was at moderate risk for skin breakdown. R3's record was reviewed from 5/1/23 to 9/20/23 and no identification of when or how the unstageable pressure ulcer was first found, however the wound clinic saw R3 on 6/13/23. The medical record does not indicate if R3's pressure ulcer wound was reassessed or if a provider was notified of the missed dressing changes. Further, there was no indication a comprehensive wound assessment was completed for 14 days, between 6/13/23 and 6/27/23. R3's integrated wound care note, dated 6/28/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was deteriorating with 80% soft moist necrotic tissue (dead tissue), 15% adherent slough (nonviable tissue) and 5% granulation tissue with a small to moderate amount of serosanguinous drainage measuring 3.3 cm x 1.2 cm x 0.2 cm total circumference of 3.96 cm. Autolytic (using chemical enzymes to debride)-chemical (Vashe), enzymatic (Santyl), and mechanical debridement performed with cares. Treatment recommendations are to cleanse with Vashe, pat dry, apply skin prep to periphery, apply nickel thin amount of Santyl to non-intact area only; cover with 1 -2 layers of xeroform (non-adherent primary dressing maintains a moist wound environment to promote wound healing), secure	F 686			

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F 686	Continued From page 5 with gauze border dressing. New Order to modify cushion of wheelchair due to pressure ridge against wound, plan of care discussed with staff. R3's integrated wound care note, dated 7/5/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 60% eschar and 40% slough with a moderate amount of serosanguinous drainage measuring 2.5 cm x 1.8 cm total circumference of 4.5 cm. Autolytic chemical (Vashe), enzymatic (Santyl), and mechanical debridement performed with cares. Treatment recommendations are to cleanse with Vashe; apply Santyl; calcium alginate-no silver (turns into a gel as they come in contact with wound exudate to provide a moist wound environment that facilitates autolytic debridement); and cover with silicone border dressing. New Order to lay down in bed after breakfast and lunch for at least 90 minutes daily and modify cushion of wheelchair due to pressure ridge against wound. Plan of care to consult therapy for proper chair fitting and discussed with facility staff. R3's integrated wound note dated 7/11/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 60% eschar and 40% slough with a moderate amount of serosanguinous drainage measuring 3.5 cm x 1.5 cm x 0.3 cm, total circumference of 5.25 cm. Treatment recommendations are no new changes to dressing. Reiterated to have [R3] lay down in bed after breakfast and lunch for at least 90 minutes daily and modify cushion of wheelchair due to pressure ridge against wound. Plan of care to	F 686			

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F 686	Continued From page 6 consult therapy for proper chair fitting and discussed with facility staff. R3's Order Summary, dated 7/14/23, to turn and reposition every two to three hours, float heels off bed. R3's integrated wound care note dated 7/18/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 60% slough and 40% granulation with a moderate amount of purulent drainage (a thick, milky white discharge indicating an unhealthy wound or infection that requires immediate attention) measuring 3.5 cm x 2.5 cm x 0.5 cm, total circumference of 8.75 cm. R3's pressure ulcer also indicated undermining at 11:00 to 1:00 measuring 1.6 cm. Treatment recommendations are no new changes to dressing. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care discussed with facility staff. R3's TAR, dated July 2023, indicated R3's pressure ulcer dressing was not changed on 7/15/23 and 7/31/23 indicated by a blank space where the signature of the nurse who performed the dressing change under those dates. Further indicated there was a new order on 7/14/23, for R3 to be turned and repositioned every two to three hours, there were several hours where this was not completed for R3 on the following days: 7/15/23, 7/19/23, 7/20/23, 7/21/23, 7/22/23, 7/24/23, 7/26/23, 7/27/23 and 7/31/23, the spaces provided were left blank. R3's record lacked wound assessments for 13	F 686			

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F 686	Continued From page 7 days, between 7/18/23 and 8/1/23. R3's quarterly MDS, dated 8/1/23, indicated R3 was at risk for pressure ulcers, and had an unstageable pressure ulcer that was not present upon admission, which required a pressure ulcer device for bed, pressure ulcer care and applications of ointments/medications other than to feet. R3's MDS lacked a pressure reducing device for R3's chair and lacked a turning and repositioning program for pressure ulcer prevention. Last identified physical therapy (PT) services were 3/23/21 to 5/5/21. R3's Braden Scale for Predicting Pressure Sore Risk Assessment dated 8/1/23, indicated a score of 14 indicating R3 was at moderate risk for skin breakdown. Further indicated R3 was completely limited with ability to respond to meaningfully pressure related discomfort, skin is often, but not always moist, ability to walk is severely limited or non-existent, cannot bear own weight and/or must be assisted into own chair or bed, very limited ability to change and control body position, can make occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. R3's integrated wound care note dated 8/1/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 60% granulation and 40% slough with a moderate amount of purulent drainage measuring 3.5 cm x 2 cm x 0.3 cm, total circumference measured 7 cm. R3's pressure ulcer also indicated undermining at 11:00 to 1:00 measuring 1.5 cm. Treatment recommendations are no new changes to dressing. Further	F 686			

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F 686	Continued From page 8 indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs treatment evaluation for wheelchair fitting and discussed with facility staff. R3's integrated wound care note dated 8/8/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound had no change with 90% granulation and 10% slough with a moderate amount of serosanguinous drainage measuring 3.6 cm x 2.5 cm x 0.3 cm, total circumference measured 9 cm. R3's pressure ulcer also indicated undermining at 11:00 to 1:00 measuring 1.0 cm. Treatment recommendations are no new dressing changes to dressing. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs PT evaluation for new wheelchair fitting and seat cushion and discussed with facility staff. R3's TAR, dated August 2023, indicated R3's pressure ulcer dressing was not changed on 8/19/23, indicated by a blank space where the signature of the nurse who performed the dressing change should be under that date. R3 was to be turned and repositioned every two to three hours, there were several hours where this was not completed for R3 on the following days: 8/7/23, 8/8/23, 8/9/23, 8/12/23, 8/13/23, 8/19/23, 8/23/23, 8/28/23, 8/30/23 and 8/31/23, the spaces provided were left blank. R3's record lacked comprehensive wound assessments for 19 days from 8/9/23 to 8/28/23.	F 686			

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F 686	Continued From page 9 R3's integrated wound care note dated 8/28/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 3.0 cm x 1.6 cm x 0.2 cm, total circumference measured 4.8 cm. No indication of undermining. Treatment recommendations are no new dressing changes ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs PT evaluation for new wheelchair and seat cushion and discussed with facility staff. R3's integrated wound care note dated 9/5/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 2.5 cm x 2.0 cm x 0.1 cm, total circumference measured 5.0 cm. Treatment recommendations are no new dressing changes ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care-needs PT evaluation for new wheelchair and seat cushion and discussed with facility staff. R3's active Order Summary, dated 9/7/23, Needs PT eval for new wheelchair and seat cushion. Pressure relief/offloading, pressure ulcer prevention protocol to include pressure redistribution mattress, heel offloading and turn and repositioning. R3's integrated wound care note dated 9/12/23,	F 686			

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F 686	Continued From page 10 indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 1.8 cm x 1.5 cm x 0.1 cm, total circumference measured 2.7 cm. Treatment recommendations are no new dressing changes ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care- discussed with facility staff. R3's integrated wound care note dated 9/19/23, indicated R3's unstageable pressure ulcer to right posterior inferior thigh was evaluated and assessed. Physical exam indicated the wound was improving with 100% granulation tissue with a moderate amount of serosanguinous drainage measuring 2.5 cm x 1.5 cm x 0.1 cm, total circumference measured 3.75 cm. Treatment recommendations are no new dressing change ordered. Further indicated, MUST lay down in bed after meals. MUST have therapy evaluation for new wheelchair and wheelchair cushion. Plan of care- discussed with facility staff. R3's TAR, dated September 2023, indicated R3 was to be turned and repositioned every two to three hours, there were several hours where this was not completed for R3 on the following days: 9/4/23, 9/7/23, 9/11/23, and 9/18/23 the spaces provided were left blank. During an observation on 9/19/23, at 3:12 p.m. R3 was seated in a Tilt-In Space wheelchair watching television in his room, R3's right and left thigh are resting at the lip of R3's wheelchair cushion with both feet dangling, nothing to rest	F 686			

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F 686	Continued From page 11 the feet on to remove pressure from the thigh area. During an observation on 9/20/23, at 10:49 a.m. R3 was seated in a Tilt-In Space wheelchair watching television in his room, R3's right and left thigh are resting at the lip of R3's wheelchair cushion with both feet dangling, nothing to rest the feet on to remove pressure from the thigh area. During an observation on 9/20/23, at 1:42 p.m. PT-A pulled back the dressing affixed to R3's right posterior inferior thigh, wound bed was red and bumpy indicating granulation tissue with a small amount of slough, cream colored tissue around the edges of the wound bed. No redness surrounding the wound, the dressing had a small amount of serosanguinous drainage noted. During an observation and interview on 9/20/23, at 12:47 p.m. R3 was seated in wheelchair in the dining room and had just finished eating his lunch, nursing assistant (NA)-A started wheeling R3 down the hall to his room and positioned R3 in front of his television next to his bed, R3's feet continue to have no support to offload pressure to thigh area. NA-A stated she got R3 out of bed and into his wheelchair at 7:30 a.m. NA-A stated we do not have enough staff on this floor to get R3 laid down after breakfast, we do not even get everyone up and out of bed today until almost 11:00 a.m. NA-A verified R3 had not been repositioned for over five hours and stated an awareness of R3 having a pressure ulcer behind the right knee, that R3 should be repositioned and offloaded every 2 hours for prevention of worsening of pressure ulcers. NA-A stated she worked at the facility for over twenty years. R3	F 686			

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F 686	Continued From page 12 always had the same wheelchair and wheelchair cushion, it had not been replaced. During an interview on 9/20/23, at 12:52 p.m. nursing assistant (NA)-B stated he had worked at the facility for a couple of years and had never noticed R3 to have a new wheelchair or wheelchair cushion. NA-B was aware that R3 had a pressure ulcer and stated they did not have time to lay R3 down after breakfast to offload or reposition as they were still getting other residents out of bed and ready for the day. NA-B stated all residents who are at risk for pressure ulcers or have pressure ulcers need to be repositioned every two hours. During an interview on 9/20/23, at 1:17 p.m. director of therapy services, (DOTS)-A stated an unawareness of R3 having an unstageable pressure ulcer or any provider order for therapy to assess R3 for a new wheelchair or wheelchair cushion. DOTS-A stated she just became the director in July, there was no bridge program from the last director to me. If the provider from the wound clinic had orders for therapy to assess, the nurse rounding with the provider would put the orders in the medical record and therapy would assess and evaluate in the same day, then therapy would write out recommendations on a communication from and give one to the floor nurse, one to the nurse manager, and one to the director of nursing (DON). During an observation and interview on 9/20/23, at 1:28 p.m. physical therapist (PT)-A stated he was not aware R3 had an unstageable pressure ulcer and was not aware of any provider order to assess R3 for a new wheelchair and wheelchair cushion. PT-A and DOTS-A walked to R3's room,	F 686			

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F 686	Continued From page 13 where R3 was lying in bed. PT-A stated that [R3] had a Tilt-In Space wheelchair, and it looked like there was a specialized formed cushion for positioning in [R3's] seat. [R3] should have support on his feet otherwise all the pressure is on [R3's] thigh, right where his pressure ulcer was. PT-A stated because his feet were dangling it caused the pressure in the thigh area and the pressure was preventable. PT-A stated turning and repositioning recommendation to nursing every two hours will help until therapy could get [R3] evaluated and assessed. DOTS-A stated the cause of R3's pressure ulcer to the back of his thigh is from his wheelchair causing his legs to dangle cutting off blood supply. PT-A pulled back the dressing on the back of R3's thigh and stated the wound is 90% granulation and 10% slough, a stage 3 pressure ulcer. The DOTS-A stated therapy would have to order pressure mapping to determine high pressure areas to ensure [R3] gets the best wheelchair and cushion to prevent pressure to this thigh area and to help ensure healing. DOTS-A stated this should have been done right away when it was ordered in July. PT-A stated the best way to prevent pressure ulcers is by changing a person's lying or sitting position by turning and repositioning frequently, especially for R3 who was dependent on staff for mobility. During an interview on 9/20/23, at 1:54 p.m. licensed practical nurse (LPN)-A stated he was the nurse that rounds with the nurse practitioners every Tuesday and Wednesday and would be the nurse responsible to ensure new wound orders get put in the computer. LPN-A verified that the provider on 6/28/23, ordered for R3 to modify cushion of wheelchair due to pressure ridge against his pressure ulcer. And, further verified	F 686			

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F 686	Continued From page 14 that every weekly wound note to current date addressed that R3 needed to be assessed by therapy to have a new wheelchair and wheelchair cushion to prevent pressure to his existing pressure wound and was not aware that therapy has not yet completed it. LPN-A was unable to articulate or show documentation of how therapy was notified of this order. During an interview on 9/20/23, at 2:14 p.m. the DON verified R3's provider order for therapy to evaluate and assess the need for a new wheelchair and wheelchair cushion to help offload pressure to existing pressure ulcer was not completed. The DON stated with a new order for therapy, the order should be placed in therapy's mailbox and therapy will assess and evaluate, also the nurse is responsible for inputting the order in the computer, where therapy would see it. The DON stated his expectation is that [R3] should have been repositioned every two hours per the provider orders to help prevent pressure ulcers. The DON stated if a wound dressing change is left blank on the TAR, and there was no progress note indicating the dressing change was completed that the dressing change was not performed. All wound dressing orders would be performed as ordered. The DON stated R3's wheelchair appeared to be the cause of the unstageable pressure ulcer to the back of R3's right thigh. During an interview on 9/20/23, at 2:36 p.m. the administrator stated when a provider gives orders for a therapy evaluation it needs to be done immediately. The administrator confirmed that R3's order for therapy to evaluate and assess for a new wheelchair and cushion for pressure ulcer prevention were not performed when ordered on	F 686			

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F 686	Continued From page 15 6/28/23 and should have been. The administrator stated facility protocol is that residents should be repositioned every two hours when they have pressure ulcers. Facility policy, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated June 2022, Assessment and Recognition included the facility responsibility of: Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker.	F 686			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725			10/13/23

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F 725	Continued From page 16 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide sufficient staffing to ensure resident care needs were provided for 4 of 4 residents (R1, R3, R4, R5 and R6) who expressed concerns of not being toileted timely and concerns with dependent residents not assisted with activities of daily living (ADL's) timely. Findings include: R3 - See F686. Resident Listing printed 9/19/23, indicated 33 of 72 resident resided on the third floor. And the facility listing of residents who require two staff assist for activities of daily living included 18 of 33 residents that reside on the third floor.	F 725	1. All residents have the potential to be affected by not having sufficient staff. 2. The facility will ensure sufficient nursing staffing on each floor according to current census, individual needs and facility assessment. Pagers have been implemented to allow staff to be able to respond to call lights in a timely manner. The pagers escalate to nurses and nurse managers so they can assist the resident with his/her needs. A review has been completed on resident needs to evaluate necessary staffing. 3. Nursing staff have been educated on the pager use. Leadership has been educated on appropriate staffing models for the facility. 4. Nursing staff have been educated on the attendance policy.		

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F 725	Continued From page 17 R1's quarterly minimum data set (MDS) dated 7/27/23, indicated R1's cognition was intact and diagnoses of diabetes, anxiety disorder and depression. R1 required extensive assist of two staff with bed mobility, toileting, dressing and hygiene and transfers, walking and locomotion did not occur. R1 was frequently incontinent of bowel and bladder. R1's care plan, dated 5/27/22 indicated a focus of ADL self-care needs, interventions revised on 4/12/23, identify to check for toileting every 2 hours. R1's Device Activity Report, identified R1's average call light time response from 9/16/23 to 9/21/23 were 31 minutes and 22 seconds. Call light wait dates and times over 30 minutes: Saturday, 9/16/23: 10:04 a.m. to 10:41 a.m. for a total wait time of 36 minutes and 31 seconds 11:00 a.m. to 11:44 a.m. for a total wait time of 43 minutes and 18 seconds 11:55 a.m. to 12:38 p.m. for a total wait time of 42 minutes and 35 seconds 1:22 p.m. to 3:35 p.m. for a total wit time of 132 minutes and 59 seconds 6:50 p.m. to 11:16 p.m. for a total wait time of 265 minutes and 53 seconds Sunday 9/17/23: -3:49 am until 4:22 a.m. a total wait time of 33 minutes and 42 seconds -10:21 a.m. until 11:18 a.m. for a total wait time of 56 minutes and 41 seconds -2:42 p.m. until 3:23 p.m. for a total wait time of 41 minutes and 6 seconds -6:47 p.m. until 10:22 p.m. for a total wait time of	F 725	5. A process has been defined for call-ins, a call-in log has been created, the individuals involved with the disciplinary process have been educated and demonstrated competency. 6. The facility currently does not have a mandating policy for nursing staff. 7. The DON or designee will audit the schedule and call light response times 5x/week for two weeks, then every 2 weeks for one month, then monthly to ensure that sufficient nursing staff are scheduled on each floor. All audits will be brought to QAPI to assess for compliance and continued need for audits. 8. The DON or designee will be responsible for the completion of this plan of correction.		

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F 725	Continued From page 18 214 minutes and 42 seconds Monday 9/18/23: -6:39 a.m. until 10:39 a.m. for a total wait time of 250 minutes and 27 seconds. -2:58 p.m. until 4:14 p.m. for a total wait time of 76 minutes and 3 seconds. 10:56 p.m. until 11:37 p.m. for a total wait time of 41 minutes and 40 seconds Tuesday 9/19/23: -1:46 p.m. to 2:17 pm for a total wait time of 30 minutes and 48 seconds -2:47 p.m. to 4:14 p.m. for a total wait time of 87 minutes and 28 seconds -8:02 p.m. to 8:43 p.m. for a total wait time of 41 minutes and 35 seconds During an interview on 9/19/23, at 10:24 a.m. nursing assistant (NA)-D stated, the facility was very short staffed on this floor. There were lots of times where the staff went into resident's rooms and their call lights were on and the residents were soiled or wet themselves. NA-D stated there used to be four aides scheduled and now staff cannot get basic cares completed timely. NA-D stated the floor was a very heavy floor with lots of heavy cares, with two staff assist. R1 takes an hour to get washed up in the morning alone, other residents are very timely. There were about 20 residents out of the 33 residents that require two persons assist and they only schedule three aides. NA-D stated there was no way staff have time to get everyone up for the day timely then toilet and reposition everyone timely. NA-A stated staff need to be able to provide the cares to residents, so they do not get pressure ulcers, or fall trying to get to the bathroom.	F 725			

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F 725	Continued From page 19 During an interview on 9/19/23 at 10:39 a.m. R1 stated the call light times were unbelievably scary and long. "I have had my call light on now for 15 minutes." The call light response times have not gotten better, had to sat in bowel movement for extended periods of time due to not having the call light answered. "I have my cell phone and will call the front desk if I am really nervous, but what about the people here who don't have a cell phone? It needs to change; it is scary for us." R1 was given a bell to use but the staff must not hear it. The facility did not have enough staff to answer call lights and described that one time her blood sugar got down to the 50's and she had her call light on for over an hour, no one came, she used her phone, and called 911, and the paramedics would not leave until they were sure her blood sugar was back to normal. During an interview on 9/20/23, at 10:13 am, nursing assistant (NA)-C stated the call light system is not great, the only way staff know if a call light on is to look at the black digital boards hanging up and the end of each hall, there are four of them on third floor. It will make a short beep when it first comes on, but if you are in a resident room helping someone you would never hear it. NA-C stated staff have no way of knowing how long a call light was on because when you come out of a room and see three call lights going off staff have no way to know who has had their call light on the longest. NA-C stated she gets a lot of complaints from residents about long call light wait times. NA-C stated she was very frustrated when there is no continuous beeping, no pager system, just the digital boards that hang up on the hallway that does not run continuous. NA-C stated you would have to look at it for a good minute to see if a call light is even on.	F 725			

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F 725	Continued From page 20 NA-C stated the facility is short staffed, especially on Mondays, Thursdays, and Fridays, those are the days the facility does not have a wound nurse, so the floor nurse has to do all the wound treatments. R2's wound care takes at least an hour and a half to do. There were three aides scheduled for 33 residents, and well over half of residents are high acuity requiring a two person assist, we are not able to follow each resident's care plan to completed toileting and turning and repositioning timely due to the short staffing. R4's Medicare 5-day MDS dated 8/18/23, indicated R4's cognition was intact with diagnoses of cerebral palsy and acute and chronic respiratory failure with hypoxia. R4 required extensive assist of two staff with bed mobility, toileting, dressing, hygiene and transfers, walking did not occur. R4 was frequently incontinent of bowel. R4's care plan dated 4/20/23, identified a focus of ADL self-care performance deficit related to cerebral palsy, impaired balance, and limited mobility. Interventions revised on 5/31/23 indicated R4 was totally dependent on staff for turning and repositioning while in bed, toilet use and hygiene. During an interview on 9/20/23 at 10:54 a.m. R4 stated the call light times were horrible. R4 stated if there was a real emergency, a resident would be in trouble especially if they did not have a phone because sometimes it takes two or more hours to get her call light answered. R4 stated "Sometimes I wonder if my call light even works because it takes so long to get it answered. This happened to me over the weekend" when it took staff over two hours for assistance while lying in	F 725			

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F 725	Continued From page 21 bed soiled. R4 stated the facility seemed to be short staffed over the weekend. R4's Device Activity Report, identified R4 's average call light time response from 9/16/23 to 9/21/23 were 40 minutes and 27 seconds. Call light wait dates and times over 30 minutes: Saturday, 9/16/23: 6:47 p.m. to 9:59 p.m. for a total wait time of 191 minutes and 59 seconds 10:45 p.m. to 11:21 p.m. for a total wait time of 35 minutes and 50 seconds Sunday 9/17/23: -10:08 am until 4:32 p.m. a total wait time of 383 minutes and 25 seconds. -8:24 p.m. until 9:01 p.m. for a total wait time of 36 minutes and 30 seconds -9:39 p.m. until 10:24 p.m. for a total wait time of 40 minutes and 55 seconds Monday 9/18/23: -12:40 pm until 4:14 p.m. for a total wait time of 214 minutes and 30 seconds. -5:50 p.m. until 7:16 p.m. for a total wait time of 85 minutes and 57 seconds. Tuesday 9/19/23: -10:08 am to 12:25 p.m. for a total wait time of 137 minutes and 14 seconds -7:04 p.m. to 8:16 pm for a total wait time of 72 minutes and 40 seconds R5's quarterly MDS dated 7/21/23 indicated R5's cognition was moderately impaired with diagnoses of multiple sclerosis and spastic hemiplegia affecting the left dominant side. R5 required extensive assist of two staff with bed	F 725			

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F 725	Continued From page 22 mobility, toileting, dressing, hygiene, and total dependence of two staff with transfers, walking did not occur. R5 was always incontinent of bowel. R5's care plan dated 2/19/29 indicated a focus of an ADL self-care performance deficit related to multiple sclerosis and spastic hemiplegia, interventions revised on 4/11/19 indicated R5 required extensive assist of two staff for bed mobility and to turn and reposition every two hours and required assist of two staff and a mechanical lift for transfers. An additional focus dated 9/9/20, was resident preferences, usual wake time at 8:00 a.m. During an observation and interview on 9/20/23 at 10:25 a.m. At 10:32 a.m. R5 was weakly yelling, nurse! nurse! nurse, from room 303 bed 2. The call light indicator on the wall was lit up red, but the marquee did not identify that R5's light is on. R5 stated, "I need the nurse right away." At 10:33 a.m. NA-B was seated at the north nurse's station and stated he did not hear R5 yelling, NA-B looked at the marquee and stated it should be telling us if a light is on and it is not. NA-B walked in R5's room indicated the call light indicator box on the wall was red and went on to assist R5. At 10:34 a.m. licensed practical nurse (LPN)-A was noted to unplug the scrolling marquee on the northeast hall and wait a few seconds and plugged it back in. Room 302 bed 1 lit up as did room 303 bed 2. LPN-A stated, sometimes the board goes blank, staff unplug it to reset it, that is what the maintenance have done before when that happens, and it happens quite a bit. LPN-A was unable to articulate how staff are alerted when the marquee is not functional and needs a reboot.	F 725			

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F 725	Continued From page 23 R6's quarterly MDS dated 8/28/23, indicated R6 cognition was moderately impaired with diagnoses of diabetes mellitus, stroke with hemiplegia and aphasia. R6 required extensive assist of two staff with bed mobility, toileting, dressing, hygiene, and walking did not occur. R6 was frequently incontinent of bowel and bladder. R6s care plan dated, 10/11/19, indicated a focus of resident preferences, intervention revised on 10/15/19 indicated usual wake up time is 7:00 a.m., and to turn and reposition every two hours while in bed. R6's Device Activity Report, identified R6's average call light time response from 9/16/23 to 9/20/23 was 51 minutes and 0 seconds. Call light wait dates and times over 30 minutes: Sunday 9/17/23: -10:02 am until 11:57 a.m. a total wait time of 115 minutes and 32 seconds. Monday 9/18/23: -8:49 am until 3:48 p.m. for a total wait time of 418 minutes and 52 seconds. -9:37 p.m. until 10:24 p.m. for a total wait time of 85 minutes and 57 seconds. Tuesday 9/19/23: -10:35 am to 11:59 a.m. for a total wait time of 83 minutes and 44 seconds Wednesday 9/20/23: -10:14 am to 11:11 a.m. for a total wait time of 56 minutes and 25 seconds During a continuous observation on 9/20/23 at	F 725			

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F 725	Continued From page 24 10:25 a.m. to 11:11 a.m. R6 was noted to be lying in bed with a facility gown on, R6 was unable to speak, and the call light was on. NA-A went into R6's room and shut the call light off and then went into R5's room with the Hoyer lift. During an interview on 9/20/23, at 12:47 p.m. NA-A stated due to short staffing, there is not time to get everyone up per their care plan in the morning, and no time to toilet and reposition everyone that needs it. There are 20 residents that require two persons assist. R5 and R6 require two staff and were not gotten out of bed until after 11:00 am, staff did not have time to lay R3 down after breakfast. R5 usually likes to be up by 8:00 a.m. NA-A stated staff do their best, the facility needs more staff on the floor, and there are no times for breaks. During an interview on 9/20/23 at 12:52 p.m. NA-B verified R5 and R6 did not get washed up, dressed and out of bed until after 11:00 a.m. NA-B stated they should have been out of bed before breakfast and was due to not having enough staff on the floor to provide cares to everyone. During an interview on 9/20/23 at 2:14 p.m. the DON indicated the way the call light system is set up there is no way for the aides to know if a call light goes on when they are assisting in resident rooms and they have no idea how long a light has been on, because it's on the black box at the end of each hall. The call light times are not acceptable as the facility was reviewing the audits. It is not safe, if a resident had a real emergency, like having chest pain or something, and they waited an hour to get their call light answered it may be too late. The DON stated if	F 725			

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F 725	Continued From page 25 the facility could get the pager system hooked up, then at least staff would be alerted to when a resident turns their call light on. Call lights should be answered within 10 minutes. The DON stated staffing has been a problem because the facility cut 17 staff and staffing is not based on acuity. The short staffing concern was brought forward to the owner, and he has not given the ok to staff any differently. During an interview on 9/21/23, at 12:48 p.m. administrator stated the facility continues to have call light problems, through the audits they are still too long. Using the Stanley Aerial wireless call light system, the lights above the resident doors are inoperable, and would have to be hard wired for them to work, which is not in the budget. The owner wanted maintenance to hook up the pager systems, but the facility does not have the manufacturer instructions to do so. The facility received a quote from Securitas Healthcare on 6/28/23, to have the pagers hooked up, the quote was \$2,392.50. The administrator stated the owner did not budget for that. The call light system we have in place should light up on the boards at the end of each hall and at the nurse's stations, they are only audible when a resident first puts their call light on. The boards should be running continuously until the call light is deactivated. The facility does not do any routine maintenance on the call light system, but the maintenance department does audit once a month to ensure they are working. Staffing has been a problem, they cut 17 staff and staffing is not based on acuity, the short staffing concerns have been brought forward to the owner and he has not given the ok to staff any differently. For third floor to be sufficiently staffed, to ensure all residents basic needs are met, there should be	F 725			

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F 725	Continued From page 26 two nurses and four aides on day and evening shift, there are 18 of 33 residents that require extensive assist of two staff with ADLs, which is why the facility needs four aides on to be staffing for acuity. During an interview on 9/21/23, at 3:33 p.m. the facility owner (FO) indicated an unawareness of call light malfunctions, long call waits times, and short staffing. FO was unable to articulate how he has tried to help the facility fix these issues. Facility staff schedule dated 9/18/23, 9/19/23, and 9/20/23, indicated for the day shift that one nurse, one trained medication aide (TMA), and three NAs worked the day shift, two nurses and three NAs worked the evening shift, and one nurse and two NAs worked the night shift. Facility assessment dated 7/28/23, indicated section 1.4 Acuity, indicated 300 Wing- Long Term Residents - The unit is prepared to appropriately care for residents that have complex wounds, complex medication regimes, multiple therapeutic treatments and IV therapy needs. Section 3.3 Individual staff assignment indicated consistent Assignment, we determine and review individual staff assignments for coordination and continuity of care for residents within and across staff assignments. We evaluate census and acuity when determining staffing levels necessary to provide appropriate care. A facility policy titled Answering the Call Light dated 11/2022, indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs. In addition, the policy indicated there was a call light above the room door.	F 725			

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F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light system was set-up in a functional manner to allow residents to call for staff assistance through a communication system which relays the calls directly to the staff member or a centralized work area. This had the potential to affect all 72 residents who resided within the facility. Findings include: During an observation on 9/19/23, at 8:41 a.m. on the third floor there were electronic call light display boxes (black rectangular shaped box with red colored electronic display) at the end of each hallway and one in front of the south nurses' station for a total of five boxes. There was not a box in front of the north nurse's station desk, if someone were sitting at this nurse's station they would have to get up and walk to their left or right to see the call light display boxes at the ends of the northeast and northwest hall. The display boxes displayed the room number pressed and the display identified which bed in the room needs assistance, the information continually scrolled across the box until service was no longer	F 919	1. This deficient practice has the ability to affect all residents. 2. The facility has set up a pager system in the building to allow nursing staff to carry pagers that will alert them to activated call lights. The pagers escalate to the nurses and nurse managers to ensure the call lights are answered in a timely manner. 3. The facility has educated all nursing staff on the pager system. 4. The DON or designee will audit call light response 5x/week for two weeks, then every 2 weeks for one month, then monthly to ensure that sufficient nursing staff are scheduled on each floor. All audits will be brought to QAPI to assess for compliance and continued need for audits. 5. The DON or designee will be responsible for the completion of this plan of correction.		10/13/23

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F 919	Continued From page 28 needed. No other information was displayed on the screen. Each resident room had a white light fixture above their door that was inoperable. During an interview on 9/19/23, at 8:59 a.m. with nurse manager (NM)-A was unsure whether the call light problem the facility had was fixed or not. NM-A stated there are scrolling marquees at the end of every hallway and total of 4 different ones at the ends of the north and south halls on this floor. NM-A pointed up to the end of the southwest hall that had a scrolling marquee and indicated that was what alerted staff that a call light was on. The scrolling marquee should be on continuously until the residents call light is answered. The system is not audible except when the light first is engaged, you will hear a light, quick, beep. If staff were in other resident rooms, you would be unable to hear it. The marquee does not tell you which resident put their call light on first or how long the call light was on. NM-A stated if there are three call lights are on, staff answer the light closest to us because they do not know who had their call light on first. The lights above the resident doors do not light up when the call light is engaged, and the staff do not have a pager to carry with them to alert them to when a call light goes on. NM-A stated, the facility might have the pagers now, but they have not hooked them up yet. During an interview on 9/19/23, at 10:39 a.m. R1 stated the call light times are unbelievably scary and long. "I have had my call light on now for 15 minutes. The call light response times have not gotten better for us, I have sat in my own bowel movement for extended periods of time due to not having my call light answered, I have my cell phone and will call the front desk if I am really	F 919			

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F 919	Continued From page 29 nervous, but what about the people here who don't have a cell phone? It needs to change; it is scary for us. They gave me a bell to use but they must not hear that either." During an interview on 9/20/23, at 10:13 am, nursing assistant (NA)-C stated, the call light system here is not great, the only way to know a call light's on is to look at the black digital boards hanging up and the end of each hall, there are four of them up here on third floor. It will make a short beep when it first comes on, but if you are in a resident room helping someone you would never hear it. Staff would have no way of knowing how long a call light has been on. if you come out of a room and see three call lights going off you have no way to know who has had theirs on the longest. Staff get lots of complaints from residents about long call light wait times. It is very frustrating for us, there is no continuous beeping, no pager system, just the digital boards that hang up on the hallway, and it does not run continuous so you would have to look at it for a good minute to see if a call light is even on. During an observation and interview on 9/20/23, at 10:25 a.m. the scrolling marquee at the end of the northeast hall indicated two call lights were on: room 312 bed 1 and Room 302 bed 1, there is nothing audible to alert staff that these lights are on. At 10:28 a.m. both lights go off on the marquee, but the light on the call light box on the wall of 302 bed 1 is lit up red. At 10:32 a.m. R7 weakly yelling, nurse! nurse! nurse, from room 303 bed 2. The call light indicator on the wall is lit up red, but the marquee does not identify that R7's light is on. R7 stated, "I need the nurse right away." At 10:33 a.m. NA-B was seated at the north nurse's station and stated he did not hear	F 919			

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F 919	Continued From page 30 R7 yelling, NA-B looked at the marquee and stated it should be telling us if a light is on and it is not. NA-B walked in R7's room indicated the call light indicator box on the wall was red and went on to assist R7. At 10:34 a.m. licensed practical nurse (LPN)-A was noted to unplug the scrolling marquee on the northeast hall and wait a few seconds and plugged it back in. Room 302 bed 1 lit up as did room 303 bed 2. LPN-A stated, sometimes the board goes blank, staff unplug it to reset it, that is what the maintenance do here before when that happens. It happens quite a bit. LPN-A was unable to articulate how staff are alerted when the marquee is not functional and needs a reboot. During an interview on 9/20/23, at 10:54 a.m. R6 stated, the call light times here are horrible if you had a real emergency, you would be in trouble if you did not have a phone because sometimes it takes two or more hours to get your call light answered. "Sometimes I wonder if my call light even works because it takes so long to get it answered. This happened to me over the weekend." During an interview on 9/20/23 at 2:14 p.m. DON indicated the way the call light system is set up there is no way for the aides to know if a call light goes on when they are assisting in resident rooms and they have no idea how long a light has been on, it's the black box at the end of each hall. The call light times are not acceptable as the facility was reviewing the audits. It is not safe, if a resident had a real emergency, like having chest pain or something, and they waited an hour to get their call light answered it may be too late. If the facility could get the pager system hooked up, then at least staff would be alerted to when a	F 919			

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F 919	Continued From page 31 resident turns their call light on. Call lights should be answered within 10 minutes. During an interview on 9/21/23, at 12:48 p.m. administrator stated, the facility continues to have call light problems, through the audits they are still too long. Using the Stanley Aerial wireless call light system, the lights above the resident doors are inoperable, and would have to be hard wired for them to work, which is not in the budget. The owner wanted maintenance to hook up the pager systems, but the facility does not have the manufacturer instructions to do so. The facility received a quote from Securitas Healthcare on 6/28/23, to have the pagers hooked up, the quote was \$2,392.50. The administrator stated the owner did not budget for that. The call light system we have in place should light up on the boards at the end of each hall and at the nurse's stations, they are only audible when a resident first puts their call light on. The boards should be running continuously until the call light is deactivated. The facility does not do any routine maintenance on the call light system, but the maintenance department does audits once a month to ensure they are working. A facility policy titled Answering the Call Light dated 11/2022, indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs. In addition, the policy indicated there was a call light above the room door. The facility manufacturing instructions for the call light system was requested and none was provided.	F 919			

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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 10/16/23 - 10/17/23 an onsite revisit was completed to follow up on licensing orders issued from the survey exited 9/21/23. Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was issued.	{2 000}		

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

11/06/23

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{2 000}	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF	{2 000}			

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{2 000}	Continued From page 2	{2 000}		
{2 800}	MINNESOTA STATE STATUTES/RULES. MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to provide timely assistance with personal cares and ensure residents safety to access staff while in their rooms according to the residents' assessed need and as directed by the care plan for 5 of 5 residents (R1, R2, R3, R4 and R5) reviewed for staffing needs. Findings include: R1's care plan dated 8/7/23 indicated R1 required, extensive assistance with bed mobility and total dependence with transferring via a mechanical lift. R1 required extensive assistance with dressing and toileting and total assistance with hygiene. R1 was to put on his call light when he was ready to be changed or repositioned. R1 was a high risk for falls, staff was to be sure R1's call light was in reach and encourage R1 to use for assistance as needed.	{2 800}	Corrected	11/10/23

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{2 800}	Continued From page 3 R1 needed prompt response to all requests for assistance. R1's quarterly Minimum Data Set (MDS) dated 8/8/23 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. R1 required extensive assistance of two members with bed mobility transfers and hygiene. R1's diagnoses included heart failure, fusion of the spine lumbar region, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R1 indicated call light staff response times of: 10/3/23 bed 251 minutes and 5 seconds 10/3/23 bed 36 minutes and 29 seconds 10/4/23 bed 94 minutes and 34 seconds 10/4/23 bed 341 minutes and 11 seconds 10/5/23 bed 143 minutes and 1 second 10/5/23 bed 32 minutes and 44 seconds 10/5/23 bed 43 minutes and 1 second 10/6/23 bed 210 minutes and 49 seconds 10/7/23 bed 31 minutes and 10 seconds 10/8/23 bed 26 minutes and 59 seconds 10/8/23 bed 33 minutes and 46 seconds 10/9/23 bed 36 minutes and 46 seconds 10/9/23 bed 36 minutes and 37 seconds 10/9/23 bed 34 minutes 17 seconds 10/11/23 bed 33 minutes and 43 seconds 10/12/23 bed 26 minutes and 49 seconds 10/14/23 bed 161 minutes and 21 seconds Upon observation and interview on 10/16/23 at 9:14 a.m. R1 was resting in bed. R1 had two wrinkled bath blankets under him, and he was covered with a top sheet. He had no fitted sheet on his bed. R1 was only wearing on an incontinent brief. R1 stated when he presses his call light for staff assistance the response is sometimes hours before a staff arrives to his	{2 800}			

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{2 800}	Continued From page 4 room. R1 stated he cannot get out of bed himself and if he needed his brief changed or to be repositioned in his bed, he needs to call for assistance. He stated he had sat in a soiled brief for hours. R1 stated he would start yelling from his room if the situation got "really bad". Upon interview on 10/16/23 at 9:39 a.m. Nursing assistance (NA)-C stated he had not been in R1's room yet that morning. He stated the first few hours of the day staff is "always" behind because there are only three NA's working on the floor for 33 residents and eight of the residents required mechanical lifts with the assistance of two NA's. He stated it was difficult to answer the call lights when two staff are taken up in multiple rooms upon morning cares. He stated the staff now carry pagers, so they are aware when a call light is going off, but they still can't leave a resident to assist another resident. He stated the morning cares and around lunch time were the most difficult times. NA-A stated the nurse, and the trained medication assistant (TMA) are busy completing their tasks and are unable to assist during those times. NA-A stated R1 often has the just the bath blankets on his bed as the night shift puts those on him and due to R1's obesity and poor mobility it takes a lot of time to place a proper sheet underneath him. R2's care plan dated 4/18/23 indicated R2 required extensive assistance of one staff member to dress him. He required extensive assistance of one staff member to assist with personal hygiene. R2 required total assistance of one staff for toilet use and transferring. Encourage resident to use call bell and be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to	{2 800}			

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{2 800}	Continued From page 5 all requests for Assistance as R2 was a fall risk. R2's significant change MDS dated 8/4/23 indicated R2 had a BImS score of 6 indicating severe cognitive impairment. R2 required extensive assistance of two staff members for bed mobility, transferring, dressing and personal hygiene. R2's diagnoses were a wedge compression fracture of the first lumbar vertebra, adult failure to thrive, chronic obstruction pulmonary disease, and liver disease. A device activity report dated 10/2/23 - 10/16/23 for R2 indicated call light staff response times of: 10/2/23 bed 50 minutes and 39 seconds 10/2/23 bed 79 minutes and 26 seconds 10/4/23 bed 26 minutes and 12 seconds 10/5/23 bed 31 minutes and 24 seconds 10/7/23 bed 40 minutes and 30 seconds 10/14/23 bed 31 minutes and 50 seconds 10/15/23 bed 28 minutes and 26 seconds Upon observation and interview on 10/16/23 at 9:53 a.m. R2 was seated in his room in his wheelchair. R2 was wearing soiled clothing. R2's call light was on the floor approximately 15 feet away from him by his bedside table. R2 stated he could wheel himself over to the call light but would not be able to bend over to pick it up off the floor. He stated instead of using the call light, it was easier to wheel himself out into the hallway and ask for assistance. R2 stated he usually dresses himself, but he could not recall if he slept in his clothing the previous night and dressed himself in the morning or not. Upon interview on 10/16/23 at 9:56 a.m. registered nurse (RN)-A stated she would get staff immediately to assist R2 in changing his	{2 800}			

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{2 800}	Continued From page 6 clothing. She was uncertain if R2 was dressing himself in the mornings or if staff were dressing him. RN-A believed with the call light being on the floor that R2 could use his chair to maneuver himself over to the call light and pull the cord, but stated he should have it next to him in his chair. R3 care plan dated 4/18/23 indicated R3 is totally dependent one staff for transferring, ambulating and toileting. Encourage R3 to use bell to call for assistance. Staff was to be sure residents call light was within his reach and encourage R3 to use the call light. R3 is a fall risk and requires prompt response to all requests. R3's quarterly MDS dated 8/15/23 indicated R3 had a BIMs score of 5 indicating severe cognitive impairment. R3 required extensive assistance of one staff member with bed mobility, transferring, dressing and hygiene. R3's diagnosis were pain in unspecified knee, low back pain, tremors, syncope (fainting or loss of consciousness) and collapse. A device activity report dated 10/2/23 - 10/16/23 for R3 indicated call light staff response times of: 10/8/23 bed 24 minutes and 30 seconds 10/11/23 bed 103 minutes and 4 seconds 10/14/23 bed 151 minutes and 13 seconds R3 did not use his call light 10/3/23 - 10/7/23 and 10/9/23 - 10/10/23. Upon observation and interview on 10/16/23 at 10:34 a.m. R3 was seated in a chair in his room he had a walker next to him. His call light was across room on the floor by his bedside table approximately 15 feet from R3. R3 stated he rarely uses his call light because he often doesn't have it within reach. He stated he is unable to	{2 800}			

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{2 800}	Continued From page 7 stand without assistance because he gets dizzy. He stated he had fallen at the facility but could not recall when. He stated he had gone without his call light for days. He stated he spends his time seated in his chair in his room and can see staff walking by, and he would yell for staff to come in and assist him. Upon interview on 10/16/23 at 10:40 a.m. RN-B stated R3 can walk on his own, so he could have gotten to his call light. R4's care plan dated 6/29/23 indicated R4 ambulated independently with a two wheeled walker. R4 was independent with dressing, toilet use and transferring. A revision was made to R4's care plan during the survey on 10/17/23 that R4 prefers his call light placed on his nightstand, not clipped to his bed. The care plan did not indicate any further call light interventions. R4's quarterly MDS indicated R4's short-term and long-term memory was okay. R4 used a wheelchair for ambulation. R4 was independent with activities of daily living. R4's diagnoses included hemothorax (a serious condition where blood collects between your lungs and your rib cage), opioid dependence, anxiety, and depression. A device activity report dated 10/2/2/23 - 10/16/23 for R4 indicated call light staff response times of: 10/2/23 bed 50 minutes and 22 seconds 10/2/23 bed 50 minutes and 6 seconds 10/3/23 bed 96 minutes and 25 seconds 10/3/23 bed 67 minutes and 58 seconds 10/4/23 bed 112 minutes and 13 seconds 10/4/23 bed 93 minutes and 46 seconds 10/4/23 bed 124 minutes and 22 seconds 10/5/23 bed 40 minutes and 7 seconds	{2 800}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/17/2023
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{2 800}	Continued From page 8 10/5/23 bed 34 minutes and 18 seconds 10/5/23 bed 35 minutes and 32 seconds 10/6/23 bed 125 minutes and 4 seconds 10/8/23 bed 26 minutes and 47 seconds 10/9/23 bed 42 minutes and 8 seconds 10/10/23 bed 26 minutes and 24 seconds 10/11/23 bed 25 minutes and 15 seconds 10/14/23 bed 39 minutes and 48 seconds 10/14/23 bed 42 minutes and 46 seconds 10/14/23 bed 123 minutes and 42 seconds 10/15/23 bed 40 minutes and 17 seconds 10/15/23 bed 51 minutes and 10 seconds Upon observation and interview on 10/16/23 at 10:18 a.m. R4 was in his room, slumped over in his wheelchair. R4 was shouting out, "I'm sick, I'm sick, if you're not a nurse get one." The call light on R4's wall near his bed with a part of the call lights cord missing. A piece of the cord had become unconnected, leaving on about four inches of cord connected to the outlet. The rest of the cord was not seen. RN-B came into the room, as she stated she heard R4 yelling. RN-B noticed the call light was missing part of the cord and stated she would tell maintenance. R4 stated "why have one, they don't answer then anyway, now get out and get a nurse who can help me." R5's care plan dated 7/6/23 indicated R5 required assistance of one staff member for bed mobility, transferring, and dressing. R5 was totally dependent of one staff member for toilet use. The care plan does not indicate any call light interventions. R5's admission MDS dated 7/11/23 indicated R5 had a BIMs score of 15 indicating she was cognitively intact. She required extensive assistance of one staff member for bed mobility,	{2 800}			

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{2 800}	Continued From page 9 transfers, hygiene, and toilet use. Her diagnoses were hemiplegia following a cerebral infarction affecting the left side (stroke), seizures, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R5's indicated call light staff response times of: 10/2/23 bathroom 75 minutes and 1 second 10/4/23 bathroom 29 minutes and 17 seconds 10/5/23 bathroom 54 minutes and 13 seconds 10/8/23 bathroom 41 minutes and 35 seconds 10/8/23 bathroom 24 minutes and 38 seconds 10/12/23 bathroom 22 minutes and 42 seconds Upon observation and interview on 10/16/23 at 10:53 a.m. R5 was in her bathroom. She was dressed in two hospital gowns, one with the ties in the front and one with the ties in the back. She stated she had been helped with morning cares. She stated that was not a concern, because she has improved, and she is more independent around her room. She stated that her concern was when she uses the bathroom, she still feels she is unable to clean herself well and transfer herself from the toilet. She stated she had sat on the toilet for over an hour and that makes her joints sore, and she gets dizzy. She stated it doesn't matter what time of day it is, "some days are good, others are not." Upon interview on 10/17/23 at 12:03 p.m. the Assistant Director of Nursing (ADON) stated she is uncertain what her job duties are, she mainly covers the floor, and she is responsible for infection control and training. She stated she does not have the time to "adequately" train new staff. She stated the reason the training is not adequate is because taking care of the residents needs to be the priority.	{2 800}			

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{2 800}	Continued From page 10 Upon interview on 10/17/23 at 2:37 p.m. NA-B stated when the third floor is staffed with three NA's showers get missed, residents are not in time in the morning, so they are eating breakfast late and residents are not repositioned as often as they should be. She stated over the past few weeks "some" of the days there has been a fourth NA on the floor and then cares get completed timely. She stated the best thing about having four NA" s is the residents are not upset due to late care or cares not completed at all. Upon interview on 10/17/23 at 2:46 p.m. NA-C stated she prioritizes her day when there are three NAs scheduled on the floor and the "neediest get the cares" and the other who are less "needy" try to assist themselves or don't get their teeth brushed or showers. Upon interview on 10/17/23 on 2:58 p.m. RN-C stated she is so worried about making a mistake because she is only nurse on the floor with "only a TMA." She stated she passes meds to about 16 residents, the nurse needs to perform all the blood glucose checks on the entire unit, chart on all 33 residents, complete assessments and perform admissions. She stated she gets behind on ordering medications and assessments because she doesn't have enough time. RN-C stated she is supposed to manage and assist the nursing assistants on the floor during the workday, but she does not have the time assist or guide them. Upon interview on 10/17/23 at 4:38 the DON stated he is aware cares are not getting completed with the level of staff he needs to schedule.	{2 800}			

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{2 800}	Continued From page 11 A facility policy titled Answering the Call Light dated 11/2022 indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	{2 800}			

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{F 000}	INITIAL COMMENTS On 10/16/23 - 10/17/23, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited on 9/21/23. The facility was NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. 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 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	{F 725}		11/10/23	

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

Electronically Signed

TITLE

(X6) DATE

11/06/2023

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 725}	Continued From page 1 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to provide timely assistance with personal cares and ensure residents safety to access staff while in their rooms according to the residents' assessed need and as directed by the care plan for 5 of 5 residents (R1, R2, R3, R4 and R5) reviewed for staffing needs. Findings include: R1's care plan dated 8/7/23 indicated R1 required, extensive assistance with bed mobility and total dependence with transferring via a mechanical lift. R1 required extensive assistance with dressing and toileting and total assistance with hygiene. R1 was to put on his call light when he was ready to be changed or repositioned. R1 was a high risk for falls, staff was to be sure R1's call light was in reach and encourage R1 to use for assistance as needed. R1 needed prompt response to all requests for assistance. R1's quarterly Minimum Data Set (MDS) dated	{F 725}	1. R1, R2, R3, R4 and R5 were immediately assisted with personal cares. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. The facility will ensure sufficient nursing staffing on each floor according to current census, resident acuity and facility assessment. 4. The facility will review Facility Assessment and ensure information accurately reflects needs of the facility and ability to meet standards set forth by MDH. 5. Leadership has been educated on appropriate staffing models for the facility. 6. The DON or designee will audit the schedule once weekly for two weeks, then once every 2 weeks for the next 2 weeks, then monthly thereafter to ensure that sufficient nursing staff are scheduled on each floor. All audits will be brought to QAPI to assess for compliance and continued need for audits. 7. The DON or designee will be		

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{F 725}	Continued From page 2 8/8/23 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. R1 required extensive assistance of two members with bed mobility transfers and hygiene. R1's diagnoses included heart failure, fusion of the spine lumbar region, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R1 indicated call light staff response times of: 10/3/23 bed 251 minutes and 5 seconds 10/3/23 bed 36 minutes and 29 seconds 10/4/23 bed 94 minutes and 34 seconds 10/4/23 bed 341 minutes and 11 seconds 10/5/23 bed 143 minutes and 1 second 10/5/23 bed 32 minutes and 44 seconds 10/5/23 bed 43 minutes and 1 second 10/6/23 bed 210 minutes and 49 seconds 10/7/23 bed 31 minutes and 10 seconds 10/8/23 bed 26 minutes and 59 seconds 10/8/23 bed 33 minutes and 46 seconds 10/9/23 bed 36 minutes and 46 seconds 10/9/23 bed 36 minutes and 37 seconds 10/9/23 bed 34 minutes 17 seconds 10/11/23 bed 33 minutes and 43 seconds 10/12/23 bed 26 minutes and 49 seconds 10/14/23 bed 161 minutes and 21 seconds Upon observation and interview on 10/16/23 at 9:14 a.m. R1 was resting in bed. R1 had two wrinkled bath blankets under him, and he was covered with a top sheet. He had no fitted sheet on his bed. R1 was only wearing on an incontinent brief. R1 stated when he presses his call light for staff assistance the response is sometimes hours before a staff arrives to his room. R1 stated he cannot get out of bed himself and if he needed his brief changed or to be repositioned in his bed, he needs to call for	{F 725}	responsible for the completion of this plan of correction.		

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{F 725}	Continued From page 3 assistance. He stated he had sat in a soiled brief for hours. R1 stated he would start yelling from his room if the situation got "really bad". Upon interview on 10/16/23 at 9:39 a.m. Nursing assistance (NA)-C stated he had not been in R1's room yet that morning. He stated the first few hours of the day staff is "always" behind because there are only three NA's working on the floor for 33 residents and eight of the residents required mechanical lifts with the assistance of two NA's. He stated it was difficult to answer the call lights when two staff are taken up in multiple rooms upon morning cares. He stated the staff now carry pagers, so they are aware when a call light is going off, but they still can't leave a resident to assist another resident. He stated the morning cares and around lunch time were the most difficult times. NA-A stated the nurse, and the trained medication assistant (TMA) are busy completing their tasks and are unable to assist during those times. NA-A stated R1 often has the just the bath blankets on his bed as the night shift puts those on him and due to R1's obesity and poor mobility it takes a lot of time to place a proper sheet underneath him. R2's care plan dated 4/18/23 indicated R2 required extensive assistance of one staff member to dress him. He required extensive assistance of one staff member to assist with personal hygiene. R2 required total assistance of one staff for toilet use and transferring. Encourage resident to use call bell and be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for Assistance as R2 was a fall risk.	{F 725}			

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{F 725}	Continued From page 4 R2's significant change MDS dated 8/4/23 indicated R2 had a BIMs score of 6 indicating severe cognitive impairment. R2 required extensive assistance of two staff members for bed mobility, transferring, dressing and personal hygiene. R2's diagnoses were a wedge compression fracture of the first lumbar vertebra, adult failure to thrive, chronic obstruction pulmonary disease, and liver disease. A device activity report dated 10/2/23 - 10/16/23 for R2 indicated call light staff response times of: 10/2/23 bed 50 minutes and 39 seconds 10/2/23 bed 79 minutes and 26 seconds 10/4/23 bed 26 minutes and 12 seconds 10/5/23 bed 31 minutes and 24 seconds 10/7/23 bed 40 minutes and 30 seconds 10/14/23 bed 31 minutes and 50 seconds 10/15/23 bed 28 minutes and 26 seconds Upon observation and interview on 10/16/23 at 9:53 a.m. R2 was seated in his room in his wheelchair. R2 was wearing soiled clothing. R2's call light was on the floor approximately 15 feet away from him by his bedside table. R2 stated he could wheel himself over to the call light but would not be able to bend over to pick it up off the floor. He stated instead of using the call light, it was easier to wheel himself out into the hallway and ask for assistance. R2 stated he usually dresses himself, but he could not recall if he slept in his clothing the previous night and dressed himself in the morning or not. Upon interview on 10/16/23 at 9:56 a.m. registered nurse (RN)-A stated she would get staff immediately to assist R2 in changing his clothing. She was uncertain if R2 was dressing	{F 725}			

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{F 725}	Continued From page 5 himself in the mornings or if staff were dressing him. RN-A believed with the call light being on the floor that R2 could use his chair to maneuver himself over to the call light and pull the cord, but stated he should have it next to him in his chair. R3 care plan dated 4/18/23 indicated R3 is totally dependent one staff for transferring, ambulating and toileting. Encourage R3 to use bell to call for assistance. Staff was to be sure residents call light was within his reach and encourage R3 to use the call light. R3 is a fall risk and requires prompt response to all requests. R3's quarterly MDS dated 8/15/23 indicated R3 had a BIMs score of 5 indicating severe cognitive impairment. R3 required extensive assistance of one staff member with bed mobility, transferring, dressing and hygiene. R3's diagnosis were pain in unspecified knee, low back pain, tremors, syncope (fainting or loss of consciousness) and collapse. A device activity report dated 10/2/23 - 10/16/23 for R3 indicated call light staff response times of: 10/8/23 bed 24 minutes and 30 seconds 10/11/23 bed 103 minutes and 4 seconds 10/14/23 bed 151 minutes and 13 seconds R3 did not use his call light 10/3/23 - 10/7/23 and 10/9/23 - 10/10/23. Upon observation and interview on 10/16/23 at 10:34 a.m. R3 was seated in a chair in his room he had a walker next to him. His call light was across room on the floor by his bedside table approximately 15 feet from R3. R3 stated he rarely uses his call light because he often doesn't have it within reach. He stated he is unable to	{F 725}			

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{F 725}	Continued From page 6 stand without assistance because he gets dizzy. He stated he had fallen at the facility but could not recall when. He stated he had gone without his call light for days. He stated he spends his time seated in his chair in his room and can see staff walking by, and he would yell for staff to come in and assist him. Upon interview on 10/16/23 at 10:40 a.m. RN-B stated R3 can walk on his own, so he could have gotten to his call light. R4's care plan dated 6/29/23 indicated R4 ambulated independently with a two wheeled walker. R4 was independent with dressing, toilet use and transferring. A revision was made to R4's care plan during the survey on 10/17/23 that R4 prefers his call light placed on his nightstand, not clipped to his bed. The care plan did not indicate any further call light interventions. R4's quarterly MDS indicated R4's short-term and long-term memory was okay. R4 used a wheelchair for ambulation. R4 was independent with activities of daily living. R4's diagnoses included hemothorax (a serious condition where blood collects between your lungs and your rib cage), opioid dependence, anxiety, and depression. A device activity report dated 10/2/2/23 - 10/16/23 for R4 indicated call light staff response times of: 10/2/23 bed 50 minutes and 22 seconds 10/2/23 bed 50 minutes and 6 seconds 10/3/23 bed 96 minutes and 25 seconds 10/3/23 bed 67 minutes and 58 seconds 10/4/23 bed 112 minutes and 13 seconds 10/4/23 bed 93 minutes and 46 seconds 10/4/23 bed 124 minutes and 22 seconds	{F 725}			

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{F 725}	Continued From page 7 10/5/23 bed 40 minutes and 7 seconds 10/5/23 bed 34 minutes and 18 seconds 10/5/23 bed 35 minutes and 32 seconds 10/6/23 bed 125 minutes and 4 seconds 10/8/23 bed 26 minutes and 47 seconds 10/9/23 bed 42 minutes and 8 seconds 10/10/23 bed 26 minutes and 24 seconds 10/11/23 bed 25 minutes and 15 seconds 10/14/23 bed 39 minutes and 48 seconds 10/14/23 bed 42 minutes and 46 seconds 10/14/23 bed 123 minutes and 42 seconds 10/15/23 bed 40 minutes and 17 seconds 10/15/23 bed 51 minutes and 10 seconds Upon observation and interview on 10/16/23 at 10:18 a.m. R4 was in his room, slumped over in his wheelchair. R4 was shouting out, "I'm sick, I'm sick, if you're not a nurse get one." The call light on R4's wall near his bed with a part of the call lights cord missing. A piece of the cord had become unconnected, leaving on about four inches of cord connected to the outlet. The rest of the cord was not seen. RN-B came into the room, as she stated she heard R4 yelling. RN-B noticed the call light was missing part of the cord and stated she would tell maintenance. R4 stated "why have one, they don't answer then anyway, now get out and get a nurse who can help me." R5's care plan dated 7/6/23 indicated R5 required assistance of one staff member for bed mobility, transferring, and dressing. R5 was totally dependent of one staff member for toilet use. The care plan does not indicate any call light interventions. R5's admission MDS dated 7/11/23 indicated R5 had a BIMs score of 15 indicating she was	{F 725}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/17/2023
NAME OF PROVIDER OR SUPPLIER THE TERRACE AT CRYSTAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
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{F 725}	Continued From page 8 cognitively intact. She required extensive assistance of one staff member for bed mobility, transfers, hygiene, and toilet use. Her diagnoses were hemiplegia following a cerebral infarction affecting the left side (stroke), seizures, and morbid obesity. A Device Activity Report dated 10/2/23 - 10/16/23 for R5's indicated call light staff response times of: 10/2/23 bathroom 75 minutes and 1 second 10/4/23 bathroom 29 minutes and 17 seconds 10/5/23 bathroom 54 minutes and 13 seconds 10/8/23 bathroom 41 minutes and 35 seconds 10/8/23 bathroom 24 minutes and 38 seconds 10/12/23 bathroom 22 minutes and 42 seconds Upon observation and interview on 10/16/23 at 10:53 a.m. R5 was in her bathroom. She was dressed in two hospital gowns, one with the ties in the front and one with the ties in the back. She stated she had been helped with morning cares. She stated that was not a concern, because she has improved, and she is more independent around her room. She stated that her concern was when she uses the bathroom, she still feels she is unable to clean herself well and transfer herself from the toilet. She stated she had sat on the toilet for over an hour and that makes her joints sore, and she gets dizzy. She stated it doesn't matter what time of day it is, "some days are good, others are not." Upon interview on 10/17/23 at 12:03 p.m. the Assistant Director of Nursing (ADON) stated she is uncertain what her job duties are, she mainly covers the floor, and she is responsible for infection control and training. She stated she does not have the time to "adequately" train new	{F 725}			

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{F 725}	Continued From page 9 staff. She stated the reason the training is not adequate is because taking care of the residents needs to be the priority. Upon interview on 10/17/23 at 2:37 p.m. NA-B stated when the third floor is staffed with three NA's showers get missed, residents are not in time in the morning, so they are eating breakfast late and residents are not repositioned as often as they should be. She stated over the past few weeks "some" of the days there has been a fourth NA on the floor and then cares get completed timely. She stated the best thing about having four NA" s is the residents are not upset due to late care or cares not completed at all. Upon interview on 10/17/23 at 2:46 p.m. NA-C stated she prioritizes her day when there are three NAs scheduled on the floor and the "neediest get the cares" and the other who are less "needy" try to assist themselves or don't get their teeth brushed or showers. Upon interview on 10/17/23 on 2:58 p.m. RN-C stated she is so worried about making a mistake because she is only nurse on the floor with "only a TMA." She stated she passes meds to about 16 residents, the nurse needs to perform all the blood glucose checks on the entire unit, chart on all 33 residents, complete assessments and perform admissions. She stated she gets behind on ordering medications and assessments because she doesn't have enough time. RN-C stated she is supposed to manage and assist the nursing assistants on the floor during the workday, but she does not have the time assist or guide them. Upon interview on 10/17/23 at 4:38 the DON	{F 725}			

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{F 725}	Continued From page 10 stated he is aware cares are not getting completed with the level of staff he needs to schedule. A facility policy titled Answering the Call Light dated 11/2022 indicated the purpose of this procedure is to ensure timely responses (within 10 minutes) to the resident's needs.	{F 725}			