DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
November 21, 2019

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: October 3, 2019

Dear Administrator:

On November 20, 2019, the Minnesota Department(s) of Health, completed a Post Certification Revisit (PCR) by desk review to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Electronically delivered
October 16, 2019

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

RE: CCN: 245452
Cycle Start Date: October 3, 2019

Dear Administrator:

On October 3, 2019, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
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: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

## 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 3, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 3, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.**

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245452 | A. BUILDING _____ B. WING _____ | C 10/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **EPISCOPAL CHURCH HOME OF MINNESOTA** | **1879 FERONIA AVENUE SAINT PAUL, MN 55104** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 10/3/19 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated: H5452045C at F684.<br><br>In addition, a deficiency was cited at F609 based on lack of reporting/investigation of the allegation.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 | F 609 | | 11/6/19 |

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

Electronically Signed | 10/25/2019

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 609 | Continued From page 1<br>hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to immediately report an allegation of abuse to the state agency for 1 of 2 (R1 ) residents.<br><br>Findings include:<br><br>R1's face sheet dated 10/3/19 indicated diagnoses including age related cognitive decline and cognitive communication deficit. The admission multiple data assessment dated 3/31/19 indicated a brief inventory of mental status (BIMS) score of 9 indicating moderate cognitive impairment. During observation and interview of R1 on 10/3/19 at 1:10 p.m. she was not able to answer questions about family names or recall her cares given that morning. | F 609 | Plan of Correction for resident cited: It is the policy of Episcopal Church Home that potential incidents of abuse or neglect be filed in accordance with federal regulations and in accordance with the facility Abuse Reporting and Investigation procedure.<br><br>Plan to address/prevent this deficiency for other residents: A facility audit of incidents was done on 10/03/19 and were found to be in compliance with reporting requirements.<br><br>Measures put in place to prevent reoccurrence: Facility staff are aware that all allegations of abuse made by residents and/or their family members are to be | |

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| F 609 | Continued From page 2<br>The progress note dated 8/27/19 at 6:23 a.m. indicated that R's family member called staff and reported R1 had called and said 4 people came into her room and hurt her. The progress notes had no further information about this incident.<br><br>The facility had a "Record of Customer or Family Concern dated 8/27/19 that documented that R1 had called a family member and reported 4 people came into her room in the middle of the night and hurt her. R1 was interviewed and stated "It wasn't last night but the night before, it happened with not just these two idiots but all the time". The report did not include any timeline of the interviews. When requested the administrator stated there was no vulnerable adult investigation completed, and no report to the state agency (SA).<br><br>RN-C was interviewed on 10/4/19 at 11:43 a.m., he stated he received the allegation of abuse from a family member and was on the phone for a long time, with R1 also on the phone. The report was that at approximately 4 a.m., 4 staff entered her room and held her down by the hands, and she stated she was abused. He stated the phone call happened between 5:00 and 6:00 a.m.<br><br>During an interview with RN-A on 10/3/19 at 11:00 a.m. he stated R1 was frequently confused at night and upset, and did better during the day.<br><br>RN-B was interviewed on 10/3/19 at 11:30 a.m. and verified there was no vulnerable adult investigation or report to the SA for the event on 8/27/19, she stated that R1 frequently reports to her and other staff that night staff hurt her, and has consistently said 'hurt her at night.' | F 609 | reported to the Administrator or DON immediately. Facility staff will each be provided with a copy of the ECH abuse reporting and investigation procedure and will be educated on situations that would be considered suspected maltreatment, how to report, and the timeline for reporting.<br><br>Plan to monitor: The facility DON and Administrator will audit all incident reports and family concerns weekly for one month. These results will be reviewed by the facility Quality Assurance committee until compliance is shown to be effective.<br><br>Responsible for Compliance: Administrator | |

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| F 609 | Continued From page 3<br><br>The administrator was interviewed on 10/3/19 at 4:00 p.m., and stated she heard about an incident on 8/27/19 in the morning, about 7:30 a.m.. She stated she interviewed R1 right away and and R1 said it had happened the night before, and all the time they move me around 4 people then 2. The administrator stated she watched a video camera for both nights and saw 2 staff enter the room to give cares. She stated she called back the family member and did make changes to the care plan.<br>The adminsitrator stated it was not reported as a vulnerable adult concern because R1 denied being physically injured and stated she felt safe at the facility. She stated R1 was reliable, but not always accurate in reporting. The administrator stated she saw no visible signs of bruising or injuries.<br>The administrator verified the facility policy was to report allegations of abuse immediately and to protect the resident while an investigation was conducted.<br><br>The facility policy titled 'Right to Be Free From Maltreatment' dated 10/27/16 indicates the Administrator, Director of Nursing, or designee shall be responsible for immediately reporting and investigating any report of maltreatment to the appropriate community and licensing agencies per procedure for investigation. 'The Reporting and Investigation Procedure' dated 11/1/16 directed that allegations of abuse must be immediately reported to the S.A. | F 609 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care | F 684 | | 11/6/19 |

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| F 684 | Continued From page 4<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to monitor bruising for 1 of 1 resident (R1) reviewed with bruising.<br><br>Findings inlcude:<br><br>R1's face sheet dated 10/3/19 indicated diagnoses including age related cognitive decline and cognitive communication deficit. The admission multiple data assessment dated 3/31/19 indicated a brief inventory of mental status (BIMS) score of 9 indicating moderate cognitive impairment.<br><br>The care plan dated 3/26/19 indicated R1 was on aspirin 81 mg daily and skin should be checked for bruising and reported to the nurse.<br><br>Observation of R1 on 10/3/19 at 1:10 p.m. revealed a blue dark bruise about 3 c.m. round on the right arm near the elbow, she stated they gave me a shot. The right back of the hand had a faded bruise.<br><br>RN-B was interviewed on 10/3/19 at 11:30 a.m. and stated that R1 had chronic bruising and frequently had bruises on the hands and arms. She stated the facility tracked all skin changes including bruising on the weekly skin checks. | F 684 | Plan of correction for resident cited: It is the policy of Episcopal Church Home that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive and person-centered care plan, and the resident's choices. R1's bruise noted was documented by the nurse on duty on 10/03/19 and was explainable based on the lab draw done to that area on 10/02/19 for which documentation was provided at the time of survey.<br><br>Plan to address/prevent this deficiency for other residents: The facility skin care policy was reviewed and found to be appropriate.<br><br>Measures put in place to prevent reoccurrence: All facility direct care staff will be educated on the facility policy to report and document any skin abnormalities.<br><br>Plan to monitor: Resident's weekly skin body audits will be audited for bruising or skin impairments on residents weekly for 4 weeks. Results will be reported to the facility Quality Assurance committee and | |

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| F 684 | Continued From page 5<br><br>The most recent weekly skin assessment dated 10/2/19 at 8:49 a.m. indicated no skin impairment. Lab report dated 10/2/19 indicated R1 had a blood draw at 6:20 a.m.. RN-A was shown the bruise at approximately 2:30 p.m., and stated he was not aware of the bruise.<br><br>The weekly skin assessment dated 9/10/19 indicated R1 had a scratch on the right hand from holding the side rail, there was no documentation of follow up.<br><br>The facility policy titled 'skin care' dated 10/1/15 indicated staff were to monitor skin weekly and provide follow up to skin alterations. | F 684 | will be ongoing until compliance is shown.<br><br>Responsible for Compliance: Director of Nursing | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 16, 2019

Administrator
Episcopal Church Home Of Minnesota
1879 Feronia Avenue
Saint Paul, MN 55104

Re: State Nursing Home Licensing Orders - Event ID 80ZN11

Dear Administrator:

The above facility was surveyed on October 3, 2019 through October 3, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
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: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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

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

Please feel free to call me with any questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00486 | A. BUILDING: _____ B. WING _____ | C 10/03/2019 |

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| EPISCOPAL CHURCH HOME OF MINNESOTA | 1879 FERONIA AVENUE SAINT PAUL, MN 55104 |

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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 10/3/19 surveyors of this Department's staff visited the above provider and the the facility was found NOT IN COMPLIANCE. A complaint investigation was conducted to investigate complaint H5452045C. As a result, the following correction order is issued: St. 0830 | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| EPISCOPAL CHURCH HOME OF MINNESOTA | 1879 FERONIA AVENUE SAINT PAUL, MN 55104 |

| (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 |
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| 2 000 | Continued From page 1<br>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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to monitor bruising for 1 of 1 resident (R1) reviewed with bruising.<br><br>Findings inlcude:<br><br>R1's face sheet dated 10/3/19 indicated diagnoses including age related cognitive decline and cognitive communication deficit. The admission multiple data assessment dated 3/31/19 indicated a brief inventory of mental status (BIMS) score of 9 indicating moderate | 2 830 | Corrected | 11/6/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00486 | A. BUILDING: _____ B. WING _____ | C 10/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 2 830 | Continued From page 2<br>cognitive impairment.<br><br>The care plan dated 3/26/19 indicated R1 was on aspirin 81 mg daily and skin should be checked for bruising and reported to the nurse.<br><br>Observation of R1 on 10/3/19 at 1:10 p.m. revealed a blue dark bruise about 3 c.m. round on the right arm near the elbow, she stated they gave me a shot. The right back of the hand had a faded bruise.<br><br>RN-B was interviewed on 10/3/19 at 11:30 a.m. and stated that R1 had chronic bruising and frequently had bruises on the hands and arms. She stated the facility tracked all skin changes including bruising on the weekly skin checks.<br><br>The most recent weekly skin assessment dated 10/2/19 at 8:49 a.m. indicated no skin impairment. Lab report dated 10/2/19 indicated R1 had a blood draw at 6:20 a.m.. RN-A was shown the bruise at approximately 2:30 p.m., and stated he was not aware of the bruise.<br><br>The weekly skin assessment dated 9/10/19 indicated R1 had a scratch on the right hand from holding the side rail, there was no documentation of follow up.<br><br>The facility policy titled 'skin care' dated 10/1/15 indicated staff were to monitor skin weekly and provide follow up to skin alterations.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or | 2 830 | | |

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| 2 830 | Continued From page 3<br>designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |