DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 6, 2019

Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number H5514021C

Dear Administrator:

On June 28, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 29, 2019.

Also on June 28, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy(ies):

- Civil money penalty. (42 CFR 488.430 through 488.444)

On July 30, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2019. We have determined, based on our visit, that your facility has corrected as of June 30, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 29, 2019 is rescinded as of June 30, 2019. (42 CFR 488.417 (b))

In our letter of June 28, 2019, 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), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 29, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 30, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded however, this does not apply to or affect any previously imposed NATCEP loss.

In addition, this Department recommended to the CMS Region V Office the following the remedies:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2019

Ms. Lydia Rasmussen, Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

Re: Reinspection Results - Complaint Number H5514021C

Dear Ms. Rasmussen:

On July 30, 2019 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on June 10, 2019. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically Submitted

June 28, 2019

Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number H5514021C

Dear Administrator:

On June 10, 2019, an extended standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 7, 2019, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 29, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 29, 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 29, 2019, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 10, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mala Strana Care & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 10, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

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 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 December 10, 2019 (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 DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/6/19, 6/7/19 and 6/10/19, an abbreviated survey was completed at your facility to conduct a complaint investigation for complaint H5514021C. Your facility was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint H5514021C was substantiated. An immediate jeopardy was identified at F684. The IJ began on 5/29/19 and was identified on 6/7/19. The administrator, director of nursing (DON) and nurse consultant (NC) were notified of the IJ at 2:20 p.m. on 6/7/19. The immediate jeopardy was removed on 6/7/19 however, noncompliance remained at the lower scope and severity level of G- isolated, with actual harm that is not immediate jeopardy. As a result of the IJ, an extended survey was completed 6/10/19. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/10/19

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

Electronically Signed | 07/08/2019

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 684	Continued From page 1 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely identification, evaluation, treatment and notification of the medical provider regarding a right lower extremity assessed to be cold to the touch and mottled (discoloration of the skin from constricting of the blood vessels) for 1 out of 3 residents (R1) reviewed for quality of care. This resulted in an immediate jeopardy (IJ) for R1 who developed non-viable tissue (not capable of living) resulting in progressive gangrene to her right lower leg. The IJ began on 5/29/19, when a facility licensed nurse identified the cold, mottled right lower leg but failed to further assess and notify R1's medical provider of the acute change. The IJ was identified on 6/7/19, and the administrator, director of nursing (DON) and nurse consultant (NC) were notified of the IJ at 2:20 p.m. on 6/7/19. The immediate jeopardy was removed on 6/7/19 however, noncompliance remained at the lower scope and severity level of G- isolated, with actual harm that is not immediate jeopardy. Findings include: R1's face sheet indicated an initial admission to the facility date of 2/12/16, with hemiplegia and	F 684	Identified Resident R1's family, hospice and primary care providers were notified of change in condition on 5/30/2019 in the morning. Identified resident R1's plan of care including updated orders, non-pressure skin assessment has been reviewed and updated on 6/6/2019 to reflect Ischemic right lower extremity status. Allina hospice, provider, and family were updated on plan of care, nursing orders and current skin conditions for ischemic right lower extremity on 6/6/2019. Licensed staff are being educated on Hospice Policy with coordination of care and Resident Change of Condition Policy. All current like residents are being assessed for a change of condition related to circulatory status to lower extremities and documented in progress note after completion of assessment. Any identified residents with signs or symptoms of circulatory status changes to lower extremities have been placed on clinical monitoring for poor circulatory status of lower extremities. Clinical monitoring will be added to the TAR for	

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F 684	Continued From page 2 hemiparesis following cerebral infarction affecting left side. R1's other diagnoses included hypertension (high blood pressure), type 2 diabetes mellitus, and chronic atrial fibrillation (an abnormal heart rhythm). R1's quarterly Minimum Data Sheet (MDS) assessment dated 3/26/19, indicated a moderate impairment in cognition and R1 required extensive assistance of two for bed mobility, transfers and toilet use and extensive assistance of one for personal hygiene and eating. R1's skin assessment identified a deep tissue injury, moisture associated dermatitis (inflammation of the skin) and a significant weight loss over the past 30 days. R1's current plan of care printed 6//7/19, identified altered cardiovascular status related to arrhythmia, hypertension, hyperlipidemia, and history of cerebral infarction. Interventions identified included: assess fingers and toes for warmth and color as needed. On 12/26/18, the plan of care was updated to include hospice cares. Interventions and tasks were updated to include: contact hospice with change of condition 24/7 (24 hours a day/7 days a week), maintain communication with hospice care, contact person keeping them informed of resident's condition as needed and keep hospice care informed of any changes in resident's condition. On 6/7/19, the plan of care was updated to include ischemic (inadequate blood flow) right lower extremity, with 5 digits on right lower extremity (RLE) having necrotic (the death of cells) tissue from underneath all the way to the nail bed. New interventions included: monitor necrotic toes on RLE. Ensure there is no pressure or rubbing. May wrap with dressing as needed. Monitor RLE	F 684	Q-shift monitoring and documentation for every identified change of condition. Physician will be contacted for every change of condition. If resident is symptomatic of decline in circulatory status (cool limbs, discoloration, pain), resident change of condition guideline will be initiated. Change of condition guideline is an algorithm from Care Path, along with STOP AND WATCH forms to assist clinical in determining whether medical intervention is needed. All licensed nursing staff are being trained on using this algorithm prior to their next working shift. Training will be provided by DON, nurse managers, or clinical designee with handouts included. Included in the training is the Q-shift monitoring and documentation for every identified change of condition and notification of provider and hospice and proper documentation and communication in the medical record. Ad-Hoc implemented on 6/4/19 in regards to Hospice Notification/Procedure, Provider Updating on a change of condition procedure along with improving communication and documentation in the resident’s medical record. Licensed Nursing staff to be trained on change of condition, clinical monitoring, hospice protocol, procedure of notification of provider, along with family notification. Training of all licensed nursing staff began on 6/4/2019, 6/5/2019 and 6/6/2019. DON, nurse managers, or designee will continue providing training. Licensed staff will not be scheduled to work the floor until proper training has been completed in	

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F 684	Continued From page 3 for signs and symptoms of pain and darkened area expanding past marked area. Per hospice, please use as needed oxycodone. Resident will need to be assessed via pain scale for pain as resident does not verbalize pain. Measure RLE discolored areas daily and document in progress note. If area worsens, update provider, family and hospice. Avoid weight bearing to the RLE. Use Lift to transfer. When in bed elevate right leg and use a cradle. During interview on 6/6/19 at 1:33 p.m., the certified nurse practitioner (CNP) stated on 5/30/19, she'd been conducting rounds with the medical doctor (MD) at the facility when they were approached by registered nurse (RN)-A requesting evaluation of R1's right lower leg. The CNP stated the leg was pulseless, cold and purple. The CNP stated R1 had denied pain with movement and there were no nonverbal signs of pain. The CNP stated she'd asked RN-A whether hospice had been notified and was told they had not been notified. The CNP stated she then contacted hospice who indicated if R1 wanted treatment, they should transfer her to an emergency department (ED). The CNP stated the facility then contacted the family who had requested transfer to the ED for evaluation. The CNP stated upon her review of the electronic medical record (EMR), she could determine issues with the leg had been identified on 5/29/19 at 10:20 p.m., with nursing documentation indicating the leg was cold and mottled. The CNP expressed concern that an acute situation had not been reported to hospice, the family or the medical provider. The CNP further indicated the RLE may have been re-vascularized if the change in status had been reported sooner.	F 684	regards to the above. DON or designee will perform daily audits 7 days a week x 1 week on change of condition along with updating provider and hospice, and ensuring proper documentation has been completed in the medical record. DON or designee will then perform weekly audits x 4 weeks, this includes three licensed staff members. DON will then perform audits PRN. The audit results will be reviewed by QAPI committee and changed in frequency and scope will be adjusted based on the results.	

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F 684	Continued From page 4	F 684		

An interdisciplinary nursing progress note dated 5/29/19 at 10:20 p.m., written by licensed practical nurse (LPN)-A included: "The right lower leg is cold to touch and appears to have modelling (sic), no edema. Resident denies pain, discomfort."

A progress note dated 5/30/19, at 11:25 a.m., written by RN-A included: "TMA (trained medication aide) called writer into room this A.M. to assess RLE. RLE cold to the touch below the knee but warm to the touch above the knee. LLE warm to the touch both above and below the knee. Writer asked resident if she was having any pain in that leg and she stated no. Possible occlusion suspected. [CNP] notified and assessed and agreed that possible occlusion is the most probable." The documentation further indicated the physician had also been in the facility conducting rounds and had called to find appropriate placement. RN-A's note also included: Writer also called family and informed family what was going on and asked them if they wanted resident to be sent out to ED (emergency department) or if they wanted to let it run its course. Writer informed them of what could happen if it remains untreated." The note indicated the family had ultimately requested to send R1 for treatment to try to save the limb.

A progress note dated 5/30/19, by the medical doctor (MD) included: "The cold right leg likely represents an arterial thrombus. I discussed the case with [a physician's name], interventional radiology. He said that typically this is treated with catheter directed lytic medications. This is followed by treatment of a culprit lesion the following day. The CNP will discuss options with hospice and the family."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

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F 684	Continued From page 5	F 684		

An interdisciplinary progress note dated 5/31/19 at 6:15 a.m., written by LPN-B, included: "Nurse assessed resident on Wednesday [5/29/19] and applied skin prep to heels when nurse noticed that resident's right leg was colder and more pale than her left leg. Nurse took off her compression sock and warmed it up with a blanket thinking the circulation might have been getting cut off. Nurse notified the next nurse since it was close to shift change."

An ED to hospital admission discharge summary note dated 6/3/19, indicated patient's leg was cool to the touch the night prior and was discolored on the morning of admission. The note indicated another hospital's ED confirmed R1 to have a cold, mottled, pulseless RLE and R1 was "transferred to this facility where an angiogram of RLE showed occlusion of the right distal common femoral artery, superficial femoral artery, and popliteal artery ...Her right foot was clearly non-viable and it was felt that her lower leg was also likely nonviable." Vascular surgery noted R1 would require an above-the-knee amputation if surgical options were pursued. Options were discussed with the family who opted to transition R1 to comfort cares and not pursue surgery.

During observation on 6/6/19, at 2:13 p.m., R1 was lying in a low positioned bed. She had a vascular boot on her right lower extremity and a towel was wrapped around her right foot and ankle. R1 denied pain. The toes on RLE from posterior base of toes to the toenails were black. Her RLE from ½ inch below the knee to the ankle was purple. The rest of the foot was covered with a towel. An outline drawn with pen was present at the top of the purple discoloration.

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F 684	Continued From page 6	F 684		

During interview on 6/6/19, at 2:50 p.m., family member (FM)-C indicated he was notified by the CNP on 5/30/19, that R1's leg was cold and likely had a blood clot and the family had an hour to decide what to do. He spoke with other family members and decided to send R1 to the ED. FM-C stated when she got to the ED, they were notified they could not treat the leg at that facility and would require transfer to a vascular surgeon, which was then completed. FM-C indicated he had received a phone call the previous night related to a burn to R1's arm, but he was not informed of the RLE being cold and mottled.

During observation on 6/7/19, at 8:31 a.m., R1 was in bed with cradle at bottom elevating blankets from both lower legs. R1 denied any pain. RLE was in a vascular boot and remained purple from below the knee into the foot. The toes on the RLE remained black on posterior toes to the nail beds. A 1x1 centimeter blister was present on was present on 2nd toe.

During interview on 6/7/19, at 8:33 a.m., LPN-B stated on 5/29/19, at approximately 2:00 p.m., she was putting skin cream on R1's legs and had noticed the RLE was cool to the touch, but had good capillary refill. LPN-B stated she had not assessed pulses. LPN-B described her assessment was identifying decreased circulation from the thrombo-embolic deterrent hose (TED), so she had removed the TED stocking and notified the next nurse caring for R1. The LPN-B further stated the charge RN was not notified.

During interview on 6/7/19, at 8:50 a.m., RN-A confirmed she had been asked to assess R1's lower right leg on 5/30/19, by the TMA shortly

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F 684	Continued From page 7	F 684		

after starting her shift at 6:00 a.m.. RN-A said she'd assessed R1's lower extremities and determined that the LLE was warm to the touch and normal in color and the RLE was cold to the touch and had no discoloration. RN-A indicated the hospice nurse was scheduled to see R1 that morning so RN-A's plan was to have hospice RN assess when she arrived. RN-A indicated approximately 9:00 a.m., she became aware the CNP and MD were at the facility and requested they evaluate the RLE. After the CNP and MD assessed the RLE,
RN-A said she was requested to notify hospice regarding possible arterial occlusion. RN-A then notified hospice who requested family be notified and determine if they wanted transfer to ED and further evaluation and treatment. RN-A stated she spoke with the FM-C, who after consulting other family members requested further care and treatment. R1 was then transferred to the ED.

During interview on 6/7/19 at 9:12 a.m., LPN-A stated a nursing assistant had notified her R1's leg was cold on 5/29/19, at approximately 9:30 or 10:00 p.m.. LPN-A stated she assessed the leg to be cold and mottled and consulted with a hospice nurse onsite from a different organization than R'1s. LPN-A stated she did not check for pedal pulses. LPN-A stated the hospice nurse had told her, "that is what happens at the end of life." LPN-A also stated she had consulted with other staff members including RN-B who did not go assess R1's RLE. LPN-A stated because she'd been concerned about R1's RLE, she had passed on her concern to the next shift. LPN-A stated after her shift, while she was at home, she discovered R1's Coumadin had been discontinued and she became more concerned but stated "with her being on hospice, we weren't

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thinking about it being abnormal." LPN-A stated, "With any change in condition, if a resident is on hospice, you notify them first then the provider and family. I didn't really think it was a change in condition or I would have notified them. I know now I should have called hospice."

During interview on 6/7/19 at 9:53 a.m., the CNP stated the Coumadin had been discontinued for R1 after long term use for atrial fibrillation due to a decline in health. The CNP indicated R1 was refusing her medications and meals at times and the international normalized ratio (INR) (a laboratory test used for monitoring the effects of anticoagulation treatment) was extremely variable. The CNP stated it became unsafe to continue dosing the Coumadin therefore, she'd discussed the risks and benefits with the family who had agreed to discontinue the Coumadin.

During interview on 6/7/19 at 10:04 a.m., RN-B stated she was informed R1's RLE was cold to the touch and mottled, but LPN-A had consulted a hospice nurse who'd said it was a normal process for dying and was expected. RN-B further stated, "At the time, I was not aware it was not [R1's] hospice agency nurse." RN-B verified LPN-A was concerned about R1's RLE. RN-B stated her interpretation of the conversation was LPN-A was mentioning it to her, but not reporting it to her as the charge nurse. RN-B confirmed she did not assess or examine R1's RLE and trusted LPN-A's judgement.

During interview on 6/7/19 at 10:34 a.m., the DON stated R1 had been declining so her foot being cold could have been another step in the dying process however, the DON stated, "You would expect bilateral coldness and mottling

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F 684	Continued From page 9 versus just one side." During interview on 6/7/19, at 11:50 a.m., the administrator stated a "Correction, Direction or Re-education" form had been completed on 6/6/19 with LPN-A. The form indicated corrective action included: "Employee noted change in condition and failed to update provider, hospice, and/or family as evidenced by nursing note dated 5/29/19." A policy titled "Procedure of Notification of Provider/MD:" included: 1. The floor nurse, nursing assistants, and nurse manager will monitor all residents for a change or decline in resident condition. If a change in condition or decline is noted, the floor nurse and/or nurse manager will complete a comprehensive assessment of the resident ... 2. The unit nurse/nurse supervisor will notify resident's attending physician/NP or on call physician when there has been: -A significant change in the resident's physical/emotional/mental condition -A need to alter the resident's medical treatment significantly -A need to transfer the resident to a hospital/treatment center 3. A significant change of condition is a decline or improvement in the resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. The IJ that began on 5/29/19 was removed on 6/7/19, when the facility provided an appropriate removal plan including: Implementation of training for all licensed staff on change of condition, clinical monitoring, hospice protocols, and	F 684		

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F 684	Continued From page 10 procedures for notification of provider and family;.Assessment of residents currently residing in the facility assessed for change in condition, and any residents with signs or symptoms of circulatory change to lower extremities were placed on clinical monitoring every shift. and it could be verified as having been implemented. Implementation of the removal plan was verified by document review and interview. While the immediacy was able to be removed, non-compliance remained at the lower scope and severity of G, because R1's right lower extremity continued to deteriorate.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 28, 2019

Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

Re: State Nursing Home Licensing Orders - Complaint Number H5514021C

Dear Administrator:

A complaint investigation was completed on June 6, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00811	A. BUILDING: _____ B. WING _____	C 06/10/2019

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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 6/6/19, 6/7/19 and 6/10/19, a survey was conducted to determine compliance for state licensure during a complaint investigation. H5514021C was substantiated. As a result, the following correction order is issued. The facility is enrolled in ePOC and therefore a	2 000		

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2 000	Continued From page 1 signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely identification, evaluation, treatment and notification of the medical provider regarding a right lower extremity assessed to be cold to the touch and mottled (discoloration of the skin from constricting of the blood vessels) for 1 out of 3 residents (R1) reviewed for quality of care. Findings include: R1's face sheet indicated an initial admission to the facility date of 2/12/16, with hemiplegia and hemiparesis following cerebral infarction affecting	2 830	Corrected.	6/10/19

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2 830	Continued From page 2 left side. R1's other diagnoses included hypertension (high blood pressure), type 2 diabetes mellitus, and chronic atrial fibrillation (an abnormal heart rhythm). R1's quarterly Minimum Data Sheet (MDS) assessment dated 3/26/19, indicated a moderate impairment in cognition and R1 required extensive assistance of two for bed mobility, transfers and toilet use and extensive assistance of one for personal hygiene and eating. R1's skin assessment identified a deep tissue injury, moisture associated dermatitis (inflammation of the skin) and a significant weight loss over the past 30 days. R1's current plan of care printed 6//7/19, identified altered cardiovascular status related to arrhythmia, hypertension, hyperlipidemia, and history of cerebral infarction. Interventions identified included: assess fingers and toes for warmth and color as needed. On 12/26/18, the plan of care was updated to include hospice cares. Interventions and tasks were updated to include: contact hospice with change of condition 24/7 (24 hours a day/7 days a week), maintain communication with hospice care, contact person keeping them informed of resident's condition as needed and keep hospice care informed of any changes in resident's condition. On 6/7/19, the plan of care was updated to include ischemic (inadequate blood flow) right lower extremity, with 5 digits on right lower extremity (RLE) having necrotic (the death of cells) tissue from underneath all the way to the nail bed. New interventions included: monitor necrotic toes on RLE. Ensure there is no pressure or rubbing. May wrap with dressing as needed. Monitor RLE for signs and symptoms of pain and darkened area expanding past marked area. Per hospice,	2 830		

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2 830	Continued From page 3	2 830		

please use as needed oxycodone. Resident will need to be assessed via pain scale for pain as resident does not verbalize pain. Measure RLE discolored areas daily and document in progress note. If area worsens, update provider, family and hospice. Avoid weight bearing to the RLE. Use Lift to transfer. When in bed elevate right leg and use a cradle.

During interview on 6/6/19 at 1:33 p.m., the certified nurse practitioner (CNP) stated on 5/30/19, she'd been conducting rounds with the medical doctor (MD) at the facility when they were approached by registered nurse (RN)-A requesting evaluation of R1's right lower leg. The CNP stated the leg was pulseless, cold and purple. The CNP stated R1 had denied pain with movement and there were no nonverbal signs of pain. The CNP stated she'd asked RN-A whether hospice had been notified and was told they had not been notified. The CNP stated she then contacted hospice who indicated if R1 wanted treatment, they should transfer her to an emergency department (ED). The CNP stated the facility then contacted the family who had requested transfer to the ED for evaluation. The CNP stated upon her review of the electronic medical record (EMR), she could determine issues with the leg had been identified on 5/29/19 at 10:20 p.m., with nursing documentation indicating the leg was cold and mottled. The CNP expressed concern that an acute situation had not been reported to hospice, the family or the medical provider. The CNP further indicated the RLE may have been re-vascularized if the change in status had been reported sooner.

An interdisciplinary nursing progress note dated 5/29/19 at 10:20 p.m., written by licensed practical nurse (LPN)-A included: "The right lower

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2 830	Continued From page 4 leg is cold to touch and appears to have modelling (sic), no edema. Resident denies pain, discomfort." A progress note dated 5/30/19, at 11:25 a.m., written by RN-A included: "TMA (trained medication aide) called writer into room this A.M. to assess RLE. RLE cold to the touch below the knee but warm to the touch above the knee. LLE warm to the touch both above and below the knee. Writer asked resident if she was having any pain in that leg and she stated no. Possible occlusion suspected. [CNP] notified and assessed and agreed that possible occlusion is the most probable." The documentation further indicated the physician had also been in the facility conducting rounds and had called to find appropriate placement. RN-A's note also included: Writer also called family and informed family what was going on and asked them if they wanted resident to be sent out to ED (emergency department) or if they wanted to let it run its course. Writer informed them of what could happen if it remains untreated." The note indicated the family had ultimately requested to send R1 for treatment to try to save the limb. A progress note dated 5/30/19, by the medical doctor (MD) included: "The cold right leg likely represents an arterial thrombus. I discussed the case with [a physician's name], interventional radiology. He said that typically this is treated with catheter directed lytic medications. This is followed by treatment of a culprit lesion the following day. The CNP will discuss options with hospice and the family." An interdisciplinary progress note dated 5/31/19 at 6:15 a.m., written by LPN-B, included: "Nurse assessed resident on Wednesday [5/29/19] and	2 830		

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2 830	Continued From page 5	2 830		

applied skin prep to heels when nurse noticed that resident's right leg was colder and more pale than her left leg. Nurse took off her compression sock and warmed it up with a blanket thinking the circulation might have been getting cut off. Nurse notified the next nurse since it was close to shift change."

An ED to hospital admission discharge summary note dated 6/3/19, indicated patient's leg was cool to the touch the night prior and was discolored on the morning of admission. The note indicated another hospital's ED confirmed R1 to have a cold, mottled, pulseless RLE and R1 was "transferred to this facility where an angiogram of RLE showed occlusion of the right distal common femoral artery, superficial femoral artery, and popliteal artery ...Her right foot was clearly non-viable and it was felt that her lower leg was also likely nonviable." Vascular surgery noted R1 would require an above-the-knee amputation if surgical options were pursued. Options were discussed with the family who opted to transition R1 to comfort cares and not pursue surgery.

During observation on 6/6/19, at 2:13 p.m., R1 was lying in a low positioned bed. She had a vascular boot on her right lower extremity and a towel was wrapped around her right foot and ankle. R1 denied pain. The toes on RLE from posterior base of toes to the toenails were black. Her RLE from ½ inch below the knee to the ankle was purple. The rest of the foot was covered with a towel. An outline drawn with pen was present at the top of the purple discoloration.

During interview on 6/6/19, at 2:50 p.m., family member (FM)-C indicated he was notified by the CNP on 5/30/19, that R1's leg was cold and likely had a blood clot and the family had an hour to

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2 830	Continued From page 6	2 830		

decide what to do. He spoke with other family members and decided to send R1 to the ED. FM-C stated when she got to the ED, they were notified they could not treat the leg at that facility and would require transfer to a vascular surgeon, which was then completed. FM-C indicated he had received a phone call the previous night related to a burn to R1's arm, but he was not informed of the RLE being cold and mottled.

During observation on 6/7/19, at 8:31 a.m., R1 was in bed with cradle at bottom elevating blankets from both lower legs. R1 denied any pain. RLE was in a vascular boot and remained purple from below the knee into the foot. The toes on the RLE remained black on posterior toes to the nail beds. A 1x1 centimeter blister was present on was present on 2nd toe.

During interview on 6/7/19, at 8:33 a.m., LPN-B stated on 5/29/19, at approximately 2:00 p.m., she was putting skin cream on R1's legs and had noticed the RLE was cool to the touch, but had good capillary refill. LPN-B stated she had not assessed pulses. LPN-B described her assessment was identifying decreased circulation from the thrombo-embolic deterrent hose (TED), so she had removed the TED stocking and notified the next nurse caring for R1. The LPN-B further stated the charge RN was not notified.

During interview on 6/7/19, at 8:50 a.m., RN-A confirmed she had been asked to assess R1's lower right leg on 5/30/19, by the TMA shortly after starting her shift at 6:00 a.m.. RN-A said she'd assessed R1's lower extremities and determined that the LLE was warm to the touch and normal in color and the RLE was cold to the touch and had no discoloration. RN-A indicated the hospice nurse was scheduled to see R1 that

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2 830	Continued From page 7 morning so RN-A's plan was to have hospice RN assess when she arrived. RN-A indicated approximately 9:00 a.m., she became aware the CNP and MD were at the facility and requested they evaluate the RLE. After the CNP and MD assessed the RLE, RN-A said she was requested to notify hospice regarding possible arterial occlusion. RN-A then notified hospice who requested family be notified and determine if they wanted transfer to ED and further evaluation and treatment. RN-A stated she spoke with the FM-C, who after consulting other family members requested further care and treatment. R1 was then transferred to the ED. During interview on 6/7/19 at 9:12 a.m., LPN-A stated a nursing assistant had notified her R1's leg was cold on 5/29/19, at approximately 9:30 or 10:00 p.m.. LPN-A stated she assessed the leg to be cold and mottled and consulted with a hospice nurse onsite from a different organization than R'1s. LPN-A stated she did not check for pedal pulses. LPN-A stated the hospice nurse had told her, "that is what happens at the end of life." LPN-A also stated she had consulted with other staff members including RN-B who did not go assess R1's RLE. LPN-A stated because she'd been concerned about R1's RLE, she had passed on her concern to the next shift. LPN-A stated after her shift, while she was at home, she discovered R1's Coumadin had been discontinued and she became more concerned but stated "with her being on hospice, we weren't thinking about it being abnormal." LPN-A stated, "With any change in condition, if a resident is on hospice, you notify them first then the provider and family. I didn't really think it was a change in condition or I would have notified them. I know now I should have called hospice."	2 830		

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2 830	Continued From page 8 During interview on 6/7/19 at 9:53 a.m., the CNP stated the Coumadin had been discontinued for R1 after long term use for atrial fibrillation due to a decline in health. The CNP indicated R1 was refusing her medications and meals at times and the international normalized ratio (INR) (a laboratory test used for monitoring the effects of anticoagulation treatment) was extremely variable. The CNP stated it became unsafe to continue dosing the Coumadin therefore, she'd discussed the risks and benefits with the family who had agreed to discontinue the Coumadin. During interview on 6/7/19 at 10:04 a.m., RN-B stated she was informed R1's RLE was cold to the touch and mottled, but LPN-A had consulted a hospice nurse who'd said it was a normal process for dying and was expected. RN-B further stated, "At the time, I was not aware it was not [R1's] hospice agency nurse." RN-B verified LPN-A was concerned about R1's RLE. RN-B stated her interpretation of the conversation was LPN-A was mentioning it to her, but not reporting it to her as the charge nurse. RN-B confirmed she did not assess or examine R1's RLE and trusted LPN-A's judgement. During interview on 6/7/19 at 10:34 a.m., the DON stated R1 had been declining so her foot being cold could have been another step in the dying process however, the DON stated, "You would expect bilateral coldness and mottling versus just one side." During interview on 6/7/19, at 11:50 a.m., the administrator stated a "Correction, Direction or Re-education" form had been completed on 6/6/19 with LPN-A. The form indicated corrective action included: "Employee noted change in condition and failed to update provider, hospice,	2 830		

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2 830	Continued From page 9 and/or family as evidenced by nursing note dated 5/29/19." A policy titled "Procedure of Notification of Provider/MD:" included: 1. The floor nurse, nursing assistants, and nurse manager will monitor all residents for a change or decline in resident condition. If a change in condition or decline is noted, the floor nurse and/or nurse manager will complete a comprehensive assessment of the resident ... 2. The unit nurse/nurse supervisor will notify resident's attending physician/NP or on call physician when there has been: -A significant change in the resident's physical/emotional/mental condition -A need to alter the resident's medical treatment significantly -A need to transfer the resident to a hospital/treatment center 3. A significant change of condition is a decline or improvement in the resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to assessments and change in condition , to ensure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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