DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 20, 2022

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: December 7, 2021

Dear Administrator:

On January 13, 2022, the Minnesota Department of Health completed a revisit 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
December 20, 2021

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: December 7, 2021

Dear Administrator:

On December 7, 2021, 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 March 7, 2022 (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 June 7, 2022 (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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	C 12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/7/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5617018C (MN00078964), with a deficiency cited at 689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 689	Carondelet Village 2021 Plan of	12/30/21

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

Electronically Signed | 12/28/2021

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F 689	Continued From page 1 facility failed to implement fall interventions as directed by the care plan for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/10/21, indicated R1 had a moderate cognitive impairment and diagnoses of Alzheimer's Disease, cerebral infarction (stroke) and hemiparesis (weakness or inability to move on one side of the body) to the right side. Further, R1 required total physical assistance of two staff for transfers, was not steady, and only able to stabilize with human assistance. R1's fall Care Area Assessment (CAA) dated 8/12/21, indicated R1 was at risk for falls related to impaired mobility, incontinence, and dementia. R1 had difficulty maintaining balance while sitting. R1's care plan dated 11/16/21, indicated R! was incontinent of bladder and bowel and needed assistance with toileting. The care plan also directed R1 was not to be left alone in the restroom. R1's Nursing Assistant Task Sheet dated 11/19/21, indicated R1 required R1 required incontinent cares in bed. The Nursing Assistant Task Sheet lacked indicated R1 was not to be left alone in the bathroom. Review of R1's progress notes revealed: - 11/21/21, at 9:11 a.m. indicated R1 had a fall in the bathroom while being toileted. - 11/21/21, at 11:00 a.m. indicated R1 was transferred to the bathroom using a full lift with the assistance of two student nurses. R1 was	F 689	Correction The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F689: The Agreement for Clinical Experience contract (effective 10/5/2015) was reviewed and remains current. R1 was reassessed for bowel and bladder to ensure that the care plan remains appropriate. A facility audit was completed on all current residents to ensure there is continuity between care plans and care guides for bowel and bladder plans. Training was completed with nursing and nursing assistant staff regarding the	

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F 689	Continued From page 2 given privacy to sit on the toilet with frequent checks. R1 was found on the bathroom floor after hearing a loud bang from the students outside the door. An Occurrence Report dated 11/21/21, indicated a factor regarding R1's fall was not following R1's plan of care. During an interview on 12/7/21, at 12:19 p.m. nursing assistant (NA)-A stated she was working on R1's unit on 11/21/21. She had not worked with nursing students before and believed the student nurses were helping with resident cares. The nursing students asked for R1's care sheet and went into R1's room for cares. NA-A had offered to help, but was declined. Further, NA-A was not sure what cares the students intended to complete for R1. The students went into R1's room while their clinical instructor (CI)-A, who was on the computer, sat outside the room. NA-A stated she was surprised when R1 fell in the bathroom as R1 was too weak to use the toilet and incontinence cares were provided when R1 was in bed. NA-A was not aware of what nursing students were able to do when in the facility or how they were assigned. During an interview on 12/7/21, at 2:08 p.m. CI-A stated on 11/21/21, the care center had two nurses scheduled and there were not enough nurses for two of eight nursing students to shadow during their clinical rotation. CI-A stated she spoke with registered nurse (RN)-A on how to utilize the two remaining student nurses, who did not have a nurse to follow, and a decision was made to have the two nursing students help with cares on R1's neighborhood as there was only one nursing assistant scheduled. CI-A then	F 689	clinical experience for nursing students. The training illustrated the roles of the floor nurse during the clinical experience and prohibits students from using mechanical devices. Training will be completed with any student groups, including the students and instructors, prior to beginning their time on the floor. This is identified in a Student Orientation Toolkit provided by the facility. Administrator and Regional Clinical Director met with school faculty to discuss education that will be provided prior to students beginning their time learning in the facility. Random audits of the student clinical experiences will take place with staff and students. Audits will be reviewed at the next QA meeting for ongoing compliance and determine need for ongoing compliance.	

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F 689	Continued From page 3	F 689		

instructed the nursing students to help with resident care and informed the students she would be on the unit to assist them. Further, the nursing students were not scheduled to do resident care on this date (11/21/21) and had not prepared for resident cares. The nursing students had not received report and did not review the residents electronic medical record prior to resident care. CI-A stated the students required a staff member, or herself, in a resident's room when providing any resident cares. CI-A stated, "I pushed these two students some as this was shift number eight. I put them in a position to use their clinical thinking and their previous experiences on the unit." R1 needed morning cares completed and the students went to complete the cares as she waited outside the room. CI-A stated she checked on the students a few times when providing cares to R1. CI-A sated she did not think the students would take R1 to the bathroom, but also confirmed she did not provide that instruction to the students. Additionally, CI-A confirmed she did not review R1's care plan with the students and stated, "I should not have put them on that unit, and I should have been with them in R1's room and reviewed the care plan with them." CI-A also verbalized there was not meeting prior to clinicals, or detailed list of what students could and could not do when at the facility.

During an interview on 12/7/21, at 2:36 p.m. RN-A stated R1 required total assistance of two staff for transfers and was always incontinent. R1 was never placed on the toilet as she was too weak. On 11/21/21, there were two nurses scheduled as there were eight nursing students, so the students were helping with cares on R1's unit. RN-A stated CI-A asked her opinion regarding

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F 689	Continued From page 4	F 689		

nursing students helping with cares. RN-A stated they felt it would be okay as the nursing assistant working on R1's unit was regular staff and knew the residents.

During an interview on 12/7/21, at 3:00 p.m. the director of nursing (DON) stated there was a meeting with CI-A to discuss the upcoming clinical rotation. The DON stated the meeting was conducted regarding access students required, the nursing students experience (i.e., clinical year), and types of cares the students would be providing. The college was informed about resident care guides, facility policies, and what students were able to do when at the facility. The DON stated her understanding was nursing students would be with the instructor when providing resident cares and was not aware of the plan to have nursing students help with cares on R1's unit and CI-A had not reached out to facility leadership when the decision was made. The DON stated the expectation was for the nursing instructor to be present when a student was providing resident cares.

During an interview on 12/7/21, at 4:12 p.m. the administrator stated there was a meeting with CI-A regarding onsite clinicals and her understanding was nursing students would be mainly observing and shadowing nursing assistants and they were not providing direct cares. The administrator explained if direct care was being provided by nursing students, staff needed more communication and understanding of the nursing student roles. The administrator stated there was not any policies guiding what nursing students could/could not do. The administrator stated her expectation was for nursing students to always be with a staff

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F 689	Continued From page 5 member when providing direct cares to ensure a resident's care plan was followed, when did not occur when R1 had fell. Facility policy titled Agreement for Clinical Experience updated 8/1/15, directed, "The facility will retain responsibility for the care of clients and will maintain administrative and professional supervision of students insofar as the presence of the educational program affects direct or indirect care of clients."	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2021

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: DKU711

Dear Administrator:

The above facility was surveyed on December 7, 2021 through December 7, 2021 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	27189	A. BUILDING: _____ B. WING _____	C 12/07/2021

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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 12/7/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5617018C (MN00078964) with a licensing order issued at 830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	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 interview and document review, the facility failed to implement fall interventions as directed by the care plan for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/10/21, indicated R1 had a moderate cognitive impairment and diagnoses of Alzheimer's Disease, cerebral infarction (stroke) and hemiparesis (weakness or inability to move on	2 830	Corrected.	12/30/21

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	27189	A. BUILDING: _____ B. WING _____	C 12/07/2021

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2 830	Continued From page 3	2 830		

one side of the body) to the right side. Further, R1 required total physical assistance of two staff for transfers, was not steady, and only able to stabilize with human assistance.

R1's fall Care Area Assessment (CAA) dated 8/12/21, indicated R1 was at risk for falls related to impaired mobility, incontinence, and dementia. R1 had difficulty maintaining balance while sitting.

R1's care plan dated 11/16/21, indicated R! was incontinent of bladder and bowel and needed assistance with toileting. The care plan also directed R1 was not to be left alone in the restroom.

R1's Nursing Assistant Task Sheet dated 11/19/21, indicated R1 required R1 required incontinent cares in bed. The Nursing Assistant Task Sheet lacked indicated R1 was not to be left alone in the bathroom.

Review of R1's progress notes revealed:
- 11/21/21, at 9:11 a.m. indicated R1 had a fall in the bathroom while being toileted.
- 11/21/21, at 11:00 a.m. indicated R1 was transferred to the bathroom using a full lift with the assistance of two student nurses. R1 was given privacy to sit on the toilet with frequent checks. R1 was found on the bathroom floor after hearing a loud bang from the students outside the door.

An Occurrence Report dated 11/21/21, indicated a factor regarding R1's fall was not following R1's plan of care.

During an interview on 12/7/21, at 12:19 p.m. nursing assistant (NA)-A stated she was working on R1's unit on 11/21/21. She had not worked

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2 830	Continued From page 4 with nursing students before and believed the student nurses were helping with resident cares. The nursing students asked for R1's care sheet and went into R1's room for cares. NA-A had offered to help, but was declined. Further, NA-A was not sure what cares the students intended to complete for R1. The students went into R1's room while their clinical instructor (CI)-A, who was on the computer, sat outside the room. NA-A stated she was surprised when R1 fell in the bathroom as R1 was too weak to use the toilet and incontinence cares were provided when R1 was in bed. NA-A was not aware of what nursing students were able to do when in the facility or how they were assigned. During an interview on 12/7/21, at 2:08 p.m. CI-A stated on 11/21/21, the care center had two nurses scheduled and there were not enough nurses for two of eight nursing students to shadow during their clinical rotation. CI-A stated she spoke with registered nurse (RN)-A on how to utilize the two remaining student nurses, who did not have a nurse to follow, and a decision was made to have the two nursing students help with cares on R1's neighborhood as there was only one nursing assistant scheduled. CI-A then instructed the nursing students to help with resident care and informed the students she would be on the unit to assist them. Further, the nursing students were not scheduled to do resident care on this date (11/21/21) and had not prepared for resident cares. The nursing students had not received report and did not review the residents electronic medical record prior to resident care. CI-A stated the students required a staff member, or herself, in a resident's room when providing any resident cares. CI-A stated, "I pushed these two students some as this was shift number eight. I put them in a position to use their	2 830		

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2 830	Continued From page 5	2 830		

clinical thinking and their previous experiences on the unit." R1 needed morning cares completed and the students went to complete the cares as she waited outside the room. CI-A stated she checked on the students a few times when providing cares to R1. CI-A sated she did not think the students would take R1 to the bathroom, but also confirmed she did not provide that instruction to the students. Additionally, CI-A confirmed she did not review R1's care plan with the students and stated, "I should not have put them on that unit, and I should have been with them in R1's room and reviewed the care plan with them." CI-A also verbalized there was not meeting prior to clinicals, or detailed list of what students could and could not do when at the facility.

During an interview on 12/7/21, at 2:36 p.m. RN-A stated R1 required total assistance of two staff for transfers and was always incontinent. R1 was never placed on the toilet as she was too weak. On 11/21/21, there were two nurses scheduled as there were eight nursing students, so the students were helping with cares on R1's unit. RN-A stated CI-A asked her opinion regarding nursing students helping with cares. RN-A stated they felt it would be okay as the nursing assistant working on R1's unit was regular staff and knew the residents.

During an interview on 12/7/21, at 3:00 p.m. the director of nursing (DON) stated there was a meeting with CI-A to discuss the upcoming clinical rotation. The DON stated the meeting was conducted regarding access students required, the nursing students experience (i.e., clinical year), and types of cares the students would be providing. The college was informed about resident care guides, facility policies, and what

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2 830	Continued From page 6 students were able to do when at the facility. The DON stated her understanding was nursing students would be with the instructor when providing resident cares and was not aware of the plan to have nursing students help with cares on R1's unit and CI-A had not reached out to facility leadership when the decision was made. The DON stated the expectation was for the nursing instructor to be present when a student was providing resident cares. During an interview on 12/7/21, at 4:12 p.m. the administrator stated there was a meeting with CI-A regarding onsite clinicals and her understanding was nursing students would be mainly observing and shadowing nursing assistants and they were not providing direct cares. The administrator explained if direct care was being provided by nursing students, staff needed more communication and understanding of the nursing student roles. The administrator stated there was not any policies guiding what nursing students could/could not do. The administrator stated her expectation was for nursing students to always be with a staff member when providing direct cares to ensure a resident's care plan was followed, when did not occur when R1 had fell. Facility policy titled Agreement for Clinical Experience updated 8/1/15, directed, "The facility will retain responsibility for the care of clients and will maintain administrative and professional supervision of students insofar as the presence of the educational program affects direct or indirect care of clients." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON), or designee, could develop, review and/or revise policies and	2 830		

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2 830	Continued From page 7 procedures to ensure supervision is provided to nursing students when providing care to ensure residents' plan of care are followed. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		