STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43205 Based on observations, interviews, and record review, the facility failed to promptly identify and intervene for an acute change in condition for 1 out of 11 residents (R39), when R39 was exhibiting signs and symptoms of cardiopulmonary distress and was left unattended resulting an unwitnessed arrest and ultimate death. This resulted in an Immediate Jeopardy (IJ) for R39. The IJ began on [DATE] at 9:00 p.m.when the facility failed to provide ongoing assessment and monitoring of R39 who was having shortness of breath, chest discomfort, dizziness, which ultimately resulted in cardiac arrest. The vice president of operations (VPO), director of clinical services (DOCS), director of nursing (DON), and infection preventionist (IP) were notified of the IJ on [DATE] at 6:02 p.m. The IJ was removed on [DATE] at 1:35 p.m., but noncompliance remained at the lower scope and severity level of D which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R39's Face Sheet dated [DATE], indicated R39 with diagnoses of cardiovascular disease, congestive heart failure (CHF), atrial fibrillation, peripheral vascular disease (PVD), prosthetic aortic valve, respiratory failure with hypoxia, end stage renal disease (ESRD) and dependence on renal dialysis, and obstructive sleep apnea (OSA). R39's health history and physical exam dated [DATE], documented R39's fourth hospitalization for respiratory failure since late 2021 with symptoms of shortness of breath (SOB), tachypnea (rapid respiratory rate), and tachycardia (rapid heart rate). R39's Minimum Data Set (MDS) dated [DATE], indicated R39 was cognitively intact, makes self-understood, exhibited no signs of delirium (temporary mental state characterized by confusion and anxiety), and required limited assistance with bed mobility, transferring, walking in hallway corridors, locomotion, dressing, toileting, and personal hygiene. R39's MDS identified R39 did not use oxygen. R39's care plan dated [DATE], indicated R39 at risk for nutritional status related to ESRD and need for dialysis and ensure no significant weight changes, alteration in kidney function and to monitor for edema in extremities and report any increase to physician, activities of daily living (ADL's) self-care deficit, and had impaired cardiovascular status related to arteriosclerotic heart disease (ASHD), cardiac dysrhythmia's, CHF, and PVD which included: (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-assess breath sounds as necessary and report abnormalities. -assess productive/nonproductive cough, SOB/exertional dyspnea, dyspnea at rest, paroxysmal night dyspnea, or orthopnea. -listen to patient when verbalizing concerns over disease symptoms and address issues raised. -monitor oxygen saturation. -monitor weight and report significant changes. -observe and report headaches, flushing, nosebleeds, nausea, and SOB. -observe and report signs of chest pain, edema, SOB, abnormal pedal pulse, restlessness, and fatigue. -observe for abnormal vital signs and report. -observe for changes in condition. -observe for sensory changes to extremities such as pain, warmth, and redness. R39's physician orders dated [DATE], included 1.5 Liters (L) fluid restriction. On [DATE], physician orders included full code and attempt resuscitation/cardiopulmonary resuscitation (CPR)- see Physician Orders for Life Sustaining Treatment (POLST) which included use intubation, advance airway interventions, mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments. On [DATE], orders indicated bi-pap on home settings ,d+[DATE] and to document refusal if needed. A progress note dated [DATE], at 4:23 p.m. registered dietician (RD) indicated R39 had a weight warning of +5.0% weight gain change over 30 days with a current weight of 186.6 pounds. RD indicated R39 triggered above weight gain which fluctuations may be expected related to dialysis status. RD indicated will continue to monitor and make recommendations as needed. A progress note dated [DATE], at 3:07 p.m. RD documented a weight warning of +5.0% change over 30 days with a current weight of 188.6 pounds and a current weight gain of +7.5% change. R39 triggered above weight gains which fluctuations may be expected related to dialysis status. RD indicated will continue to monitor and make recommendations as needed. R39's record lacked a comprehensive analysis of the weight gain and did not describe what type of monitoring was initiated and/or revision in the care plan after the weight gain was identified. A progress note dated [DATE], at 10:45 a.m. registered nurse (RN)-C documented it was reported to her R39 complained of sore throat and SOB on the evening shift. RN-C checked on R39 after getting report and asked her if she was having any COVID symptoms like chest pain, fever, and SOB but R39 declined. R39's temperature was 98.7 degrees Fahrenheit (F) and O2 saturation was 96% on room air. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R39's record did not identify R39's symptoms on [DATE] and [DATE] as reported to the evening nurse, lacked evidence of assessment, monitoring, intervention, and physician notification. In addition, the record lacked evidence of ongoing comprehensive assessments and consistent monitoring of reported symptoms through [DATE]. R39 's electronic medical record (EMR) dated [DATE], at 3:47 a.m. identified 02 saturations were 96% on room air and temperature was 98.2 degrees F. R39's record lacked any further vital signs and comprehensive respiratory or cardiac assessment. The record did not identify why R39's oxygen saturation and temp was checked at that time. During an observation on [DATE], at 6:10 a.m. observed ambulance driving down the road with flashing lights on and it turned into facility parking lot and two emergency medical technicians (EMTs) went into side door of facility. At 6:20 a.m. observed ambulance chaser vehicle pull into facility parking lot and a third gentleman reported into facility. During an observation on [DATE], at 6:30 a.m. facility staff on 2nd floor notified surveyors that a code was happening down the hallway on 2 East. At 6:45 a.m. observed ambulance members packing up their equipment without taking a resident to the hospital. A progress note dated [DATE], at 7:30 a.m. RN-C documented nursing assistant (NA)-H called her at 5:40 am stating R39 needs help to use the bathroom but R39 was dizzy. RN-C went to R39's room and R39 confirmed she wanted to go to the bathroom. R39 and NA-H helped her back in bed. R39's O2 saturation was 88% on room air and respirations were 22. R39 complained of SOB, put on 2 Liters (L) of O2, O2 saturation was 93%, and blood pressure (BP) was ,d+[DATE]. At 5:45 a.m., RN-C went to call ambulance and called RN-E to help with printing paperwork needed to send R39 to hospital. Paramedics arrived, did CPR, and pronounced R39 dead at 6:40 a.m. At 7:20 a.m. RN-C called family to notify of death and discussed with them to call facility back to arrange for a funeral home of choice. During an observation and interview on [DATE], at 9:36 a.m. R39's room was observed cluttered with debris from the code that occurred earlier in morning with a white cotton bath blanket covering the entire bed of R39. R5 stated her roommate passed away unexpectedly after having chest pain for a while and needed to go to the hospital. When interviewed on [DATE], at 9:15 a.m. licensed practical nurse (LPN)-A stated she arrived for her day shift at 6:00 a.m. and noticed RN-C and RN-E at 2nd floor main nursing desk preparing paperwork. LPN-A stated she heard EMS yell for code help in the hallway just outside R39's room. LPN-A stated R39 was pulseless and not breathing upon her arrival to room and CPR was initiated already by EMS. LPN-A stated EMS asked facility staff to verify R39's code status, retrieve the crash cart and bag valve mask from the facility. When interviewed on [DATE], at 10:45 a.m. NA-C stated NA-A ran up to 3rd floor memory care unit on [DATE] at approximately 6:20 a.m. and asked where the facility kept an ambu bag. NA-F stated R39's death was unexpected as she fed R39 last evening for dinner and she appeared fine. When interviewed on [DATE], at 11:00 a.m. R5 stated her roommate, R39, was not feeling well the morning of [DATE]. R5 stated R39 was dizzy and had chest pain. R5 stated EMT's initiated CPR immediately upon arrival to their room on R39. R5 stated she was in the room the entire code so she overheard everything that occurred. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 1:43 p.m. RN-C indicated she went into R39's room on [DATE] at approximately 5:30 a.m. to 6:00 a.m. after a NA-H called her for assistance to help transfer R39 to the bathroom as she was unable to get there by herself with her walker. RN-C stated R39 was hypoxic(deprived of oxygen) and demonstrating signs and symptom of respiratory distress, tachypnea (increased breating rate), dizziness, and later become nauseous. RN-C indicated she had only obtained respirations which was 22 and 02 saturation was 88% on room air. RN-C grabbed portable O2 tank from the corridor and placed R39 on 2L nasal cannula (NC) and assisted R39 to lay down in bed and rechecked O2 saturation at 93%. RN-C stated she did not check R39's pulse at that time. RN-C left the room to prepare for ED transfer and did not instruct other staff to stay in the room and R39 was left alone. During that time, R39 coded and became pulseless and without respirations. RN-C stated she called RN-D from 3rd floor to come assist with gathering hospital transfer paperwork as RN-C said she had an emergency on 2nd floor East hallway. RN-C stated between the hours of 5:30 a.m. and 6:00 a.m. she went back to room to check on R39 with the last time having R39 attempt to sign bed hold paperwork for facility. R39 was unable to sign her signature at that time around 6:00 a.m. as R39 was too symptomatic and having cardiopulmonary distress. RN-C stated she was focused on getting the documents ready to send R39 out for hospital transfer. RN-C stated R39 was left unattended and alone and within 10 minutes R39 was deceased upon arrival of EMS. RN-C stated EMS had initiated CPR to R39 upon her arrival to R39's room. EMS asked facility staff for an ambu bag for respiratory resuscitation, more oxygen as the portable tank was empty, and to verify R39's code status. RN-C stated she left R39's hospital transfer paperwork at the nurses station so she had to run back to nurses station to find out if R39 was a full code or not. RN-C stated the ambu bag was not in the 2nd floor crash cart as NA-A eventually brought it to R39's room. RN-C stated CPR was continued until 6:40 a.m. when EMS pronounced R39 dead. RN-C stated R39 was not medically safe enough to be left completely alone. RN-C stated if she could re-do the events over again, she would have called a NA or nurse for assistance with calling EMS and doing paperwork while she stayed with her resident who was in distress. RN-C stated she was unaware how to document a medical emergency and death in the EMR other than writing a progress note. RN-C stated she has not received any Code Blue training since she started working for facility, but was CPR certified. RN-C stated Code Blue was never activated at facility on [DATE]. During interview on [DATE], between 10:00 p.m. and 11 p.m. RN-C stated R39's temperature and O2 saturation was checked and was 96% on room air; however, the medical record lacked documentation to support this finding. RN-C further indicated a comprehensive cardiopulmonary assessment was not completed. RN-C stated she received verbal report from RN-D who reported R39 had SOB and a sore throat. During an interview on [DATE], at 4:50 p.m. RN-D stated R39 called out to her in hallway on the evening shift of [DATE] to check O2 saturations because R39 felt shortness of breath. RN-D stated O2 was 96% on room air, but could not remember what her pulse was; however, R39 put her hand over her heart, stated she was not feeling right, and took a deep breath in. R39's medical record lacked documentation or vital signs. RN-D stated R39 was very fatigued that evening and requested to go to bed earlier than normal. RN-D stated R39 wore her bi-pap machine consistently every night and R39 placed it on herself as she was highly independent. RN-D stated R39 was independent with ambulation and her 4 wheeled walker. RN-D stated she reported the abnormal signs and symptoms R39 complained of to her night shift nurse RN-C. RN-D stated R39 had previous occurrences of shortness of breath as R39 had multiple hospitalization s recently for respiratory distress. RN-D indicated despite R39's symptoms and recurrent hospitalization s further assessment and physician notification was not completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 5:00 p.m. trained medication assistant (TMA)-B stated R39 was not feeling well the evening of [DATE] during her medication pass. TMA-B stated during verbal shift report from dayshift that she heard R39 was complaining of SOB and congestion which facility staff presumed may have been signs and symptoms of Covid-19; however, R39 was swabbed on [DATE] and was negative. During an interview on [DATE], at 9:05 a.m. R5 stated she was upset that her roommate (R39) had passed away on the morning of [DATE]. R5 stated facility staff did not do CPR as they left R39 alone. R5 stated R39 was speaking to her and then suddenly stopped after she stated, I need to get to the hospital. R5 stated RN-C was working on hospital transfer as she kept leaving the room. R5 stated when EMS arrived to room, R39 did not have a heart beat and she was not breathing. R5 stated EMS started CPR and yelled for a nurse. R5 stated she overheard everything because she was in the room the entire time and only the privacy curtain was closed when EMS arrived. R5 stated R39 had been complaining of pain in her chest the day prior and asked NA for something for pain; however, the nurse never came in to speak with R39. During an interview on [DATE], at 9:32 a.m. NA-A stated R39 had ambulance called for her on [DATE] due to breathing concerns. NA-A stated she heard EMS yell for a nurse from the hallway upon their arrival to R39's room. NA-A stated R39's skin on her body was yellowish-white and her face was bluish-purple upon her arrival to R39's room. NA-A stated EMS initiated CPR prior to facility staff arriving to R39's room. NA-A stated R39 was alone with her roommate, R5, when EMS showed up to facility. NA-A stated R39 normally did not have SOB, was on room air, and wore her bi-pap every night. During an interview on [DATE], at 3:49 p.m. Mayo Clinic Ambulance assistant supervisor stated a call was placed by facility on [DATE] at 6:03 a.m. as R39 needed to be transferred to hospital for breathing problems. Mayo Clinic Ambulance assistant supervisor stated ambulance was dispatched at 6:03 a.m. and enroute to facility at same time. Ambulance arrived to facility at 6:09 a.m. and patient time to R39's room at 6:11 a.m. He stated EMS's first assessment of R39 was pulseless and without respiration. During an interview on [DATE], at 4:15 p.m. emergency medical technician (EMT)-A stated facility called ambulance for a priority two transfer which means just a hospital transfer with no lights nor siren as R39 only had shortness of breath with no other symptoms. EMT-A was not aware R39 also demonstrated symptoms of dizziness, nausea, weakness, and lethargy. EMT-A stated upon arrival to R39's room, there were not staff in the room at the time nor to be found in the hallway at the time of arrival up to 2nd floor hallway. EMT-A stated R39 was unresponsive to sternal rub, lying supine on her back in bed, no pulse, not breathing; however, R39 was still warm to the touch upon first assessment. EMT-A stated since they thought they were transferring an alert and oriented patient to the hospital, they arrived to unit without advanced cardiac life support medications, advanced airway interventions for breathing support which included an oral airway. EMT-A immediately started chest compressions while EMT-B put on the automatic external defibrillator (AED) which indicated no shockable rhythm on monitor advised. EMT-A indicated life saving interventions were not successful and EMT-A stated a decision to call the death occurred at 6:40 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 4:30 p.m. R5 stated RN-C had been in and out of room the morning of [DATE] after her roommate, R39, said she was not feeling well. R5 stated the last time RN-C was with R39 was when R39 firmly stated, I want to go to the hospital when RN-C was completing the bed hold paperwork that R39 was unable to sign. R5 stated RN-C left R39 and never came back to room. R5 stated the next people who came into their room were the paramedics. R5 stated R39 was acting very unusual and knew R39 was very sick and wanted to go to the hospital immediately. During an interview on [DATE], at 4:34 p.m. director of nursing (DON) stated expectation of nurses to complete a full comprehensive cardiopulmonary assessment on any resident in distress which included: checking O2 saturations, respiratory rate if they have respiratory distress, listening to heart and lung sounds, applying O2 as needed, and notifying physician of change in condition and family as needed. DON confirmed a Code Blue was never called the morning of [DATE] for R39 as she would not expect her staff to call one if paramedics are in the building. DON confirmed EMT's initiated CPR on R39. DON stated if there was a medical emergency with any resident expectation for the nurse to not leave a resident by themselves. During an interview on [DATE], at 6:16 p.m. EMT-B stated they received a call for a hospital transfer due to R39 complaining of SOB, EMT-B indicated an unawareness R39 had displayed other symptoms. EMT-B stated they arrived to 2nd floor East wing and there were no facility staff present. EMT-B stated R39 was found in room alone with her roommate R5. EMT-B stated R39 was halfway lying out of bed upon arrival, pulseless, not breathing, and in cardiac arrest. EMT-B stated R39's O2 nasal cannula prongs were in her nares and portable oxygen tank set to 2L; however, the tank was completely empty and not administering any oxygen flow. EMT-B stated R39 skin was very warm to touch yet so she had clear clinical signs she had recently went into cardiac arrest. EMT-B stated he ran to hallway and yelled for help to get nursing staff to come to R39's room. EMT-B stated three facility staff arrived to R39's room at the same time. EMT-B stated he immediately gave them three things to find as soon as possible which included: a bag valve mask to resuscitate R39, verify code status, and find oxygen immediately. EMT-B stated facility staff brought in an oxygen concentrator instead of a portable oxygen tank which was unable to deliver high flow oxygen to R39. EMT-B stated they were unable to adequately ventilate R39 until their EMT supervisor showed up in the chase car. EMT-B stated they administered 1 milligram epinephrine and fluids, but R39 remained in a non-shockable rhythm per AED. R39 was pronounced dead at 6:40 a.m. EMT-B stated, there was no reason why this patient had to die the way she died without giving her a fighting chance; she died alone by herself. During an interview on [DATE], at 9:44 a.m. RN-E stated she was called by RN-C on [DATE] at approximately 5:55 a.m. to 6:10 a.m. to assist her with hospital transfer paperwork. RN-E stated she asked how R39 was doing and RN-C stated, she's stable and okay with her O2 saturation being 88%. RN-E stated RN-C communicated R39 was on O2 2L nasal cannula with O2 saturations at 93% after R39 laid back in bed. RN-E stated RN-C was at 2nd floor nurses station when she arrived to floor. RN-E stated she printed off R39's hospital transfer paperwork and returned to 3rd floor as the dayshift nurse, LPN-A, was already on shift. RN-E stated that RN-C confirmed R39 was fine at the time and she just wanted to send R39 to the hospital. RN-E stated if a resident were to have a change in condition, she would call for a NA for assistance or use the intercom system in the resident's room to ask facility staff for help. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 12:40 p.m. DON stated her concern regarding nurses not noticing a change in cardiopulmonary condition and staying with a resident who was in distress could result in rapid decline. DON confirmed there is a portable phone at the nurses desk for use. DON stated she could not remember or confirm if RN-C checked R39's pulse or count respirations. The IJ was removed on [DATE], at 1:35 p.m. when it could be verified the acceptable plan of correction was implemented which included: -Applicable policies were reviewed -Nursing staff were provided with re-education regarding identification of change in condition, cardiopulmonary assessments and signs/symptoms of distress, CPR, shift to shift monitoring of resident condition when change is identified, and direct supervision of residents when displaying significant signs and symptoms of decline in health that could result in a code event. -Like residents were identified and assessed by licensed nursing staff. -An auditing system developed and implemented. The facility policy titled Change of Condition of the Resident (Observing, Recording, and Reporting) dated [DATE], indicated to observe, record, and report any condition change to the physician so proper treatment can be implemented. -Change of condition refers to a deviation from the patient/resident's baseline in physical, cognitive, behavioral, or functional domains. This change can be negative or positive. The change of condition may be short lived or extend for a period of time and presents as a shift from the norm for that specific patient/resident. -An acute change of condition refers to a sudden, clinically important deviation from a patient/resident's baseline in physical, cognitive, behavioral, or functional domains. It is clinically important in that without intervention, the patient/resident may experience complications. -Assess the resident's need for immediate care/medical attention. (CNA'S to notify nurse, nurse to notify supervisor, etc.) Provide emergency care as needed. -Do not leave resident alone. Ensure resident's safety. -Assess the resident and notify the attending practitioner of the resident's condition. Compare the resident's condition. Compare the resident's current condition to his/her prior level of functioning. -Assessment, monitoring, and documentation include, but are not limited to the following: vital signs, oxygen saturation, blood glucose level, personality/behavioral/cognitive changes, alteration in level of consciousness/ability to respond, sensory weakness/change, generalized/localized weakness, gait/posture/balance change, dyspnea/irregular breathing. -Monitor resident's condition frequently until stable or transported to higher level of care, if needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled Cardiopulmonary Resuscitation (CPR) dated [DATE], indicated to restore breathing and blood circulation to someone experiencing cardiac arrest. -CPR (Cardiopulmonary resuscitation) that is done improperly or on a resident whose heart is still beating can cause serious injury. The facility policy titled Charting and Documentation dated [DATE], indicated services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. -Incidents, accidents, or changes in the resident's condition must be recorded.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to prevent pressure ulcers development or deterioration and promote healing by failing to follow physician ordered treatments, follow the care plan, and ensure comprehensive assessments and monitoring pressure for 7 of 7 residents (R3, R4, R11, R41, R43, R42, R5) reviewed for pressure ulcers. The facility's system failures resulted in actual harm for 5 of 7 residents (R3, R4, R11, R41, R43) when new ulcers developed and/or worsened. The deficient practice has the potential to effect all residents in the facility that are at risk for pressure ulcers. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. R3's admission record identified an admitted [DATE], with diagnoses that included apraxia (difficulty with skilled movements even when a person has the ability and desire to do them), following a cerebral infarction (ischemic stroke), and neuromuscular dysfunction of the bladder. R3's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated that R3 had moderately impaired cognition, required supervision with eating and locomotion, extensive assist of one staff with all other activities of daily living (ADL)'s, and used a walker and wheelchair for mobility. Also noted to be frequently incontinent of bladder, and always incontinent of bowel. Section M indicated R3 was at risk for pressure ulcer development. No pressure ulcers identified, does note moisture associated skin damage (MASD). Pressure reducing device for chair and bed, nutrition/hydration intervention to manage skin problems. Also identified application of nonsurgical dressings other than to feet and applications of ointment/medications other than to feet. (continued on next page)

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	245184	A. Building B. Wing	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R3's care plan prior to 5/26/22, lacked a focus, goal and interventions pertaining to skin concerns. On 5/26/22, the care paln was updated to indicate R3 had actual skin integrity break and/or pressure sore, chronic non pressure wound on buttock, interventions to assess and measure all skin integrity areas per policy, monitor and report any new open areas, draining, or pain to nurse immediately, provide treatment to wound per current treatment order. Interventions do not include, repositioning or offloading pressure ulcers per current NP orders. R3's toileting care planned interventions included to toilet upon rising, before and after meals, at bedtime and as needed. R3's weekly skin review dated 4/3/22, and 4/9/22, indicated no concerns to skin on buttocks. On 4/16/22, indicated redness to bilateral butt cheeks. R3's progress note dated 4/17/22, indicated R3 was developing a new pressure ulcer at the coccyx region of her buttocks. R3's nurse practitioner (NP) progress noted dated 4/18/22, did not indicate any sacral redness. R3's progress note dated 4/20/22, indicated R3 had a moisture associated bilateral buttock injury. R3's Treatment Administration Record (TAR) dated April 2022, indicated an order on 4/30/22, to cleanse wound on buttocks with normal saline (NS) and pat dry. Apply hydrogel to open areas. Cover open areas with a border foam dressing after applying the cream. R3's weekly skin review dated 5/2/22, indicated redness and open moisture associated skin injury ([NAME]) to sacrum. R3's NP progress note dated 5/3/22, indicated R3 had an area to her sacral coccygeal (located near the tailbone) that was non-blanchable, nontender, erythema (redness). This would be indicative of a stage 1 pressure ulcer (Intact skin with non- blanchable redness of a localized area usually over a bony prominence). Assessment and plan indicated, closely daily monitor wounds, looking for signs and symptoms of infection and to continue with current orders. R3's weekly skin review, dated 5/8/22, indicated redness and open area, the site and type of impairment was not assessed. R3's NP progress note dated 5/10/22, indicated skin excoriations noted on bilateral buttocks, no open lesions present. New order: apply hydrogel to open areas on bilateral gluteal wounds, apply 3M barrier spray to surrounding skin, then cover with a foam border dressing. Change dressing daily and as needed if soiled. Encourage frequent repositioning when seated on the recliner or laying in bed. R3's TAR for May 2022, indicated a new order on 5/11/22: cleanse wound on buttocks with NS and pat dry. Apply hydrogel to open areas. Apply 3M barrier spray to surrounding skin, then cover open areas with a border foam dressing every dayshift for skin breakdown. R3's NP progress note dated 5/17/22, indicated R3's wounds to her buttocks have significantly improved, no signs and symptoms of infection noted today. Opened areas on right buttock have completely scabbed over, left buttock is healing gradually, will continue with current plan of care. Nursing to ensure that R3's buttocks are separated apart prior to applying foam dressing to minimize the chances of moisture buildup. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R3's progress note dated 5/22/22, indicated when given a bath, a stage 1 pressure ulcer noted to coccyx. Review of R3's record identified there were no further weekly comprehensive skin assessments after 5/8/22 completed by facility registered nurses. Review of R3's record also did not identify root cause of the skin break down nor an assessment/evaluation of the effectiveness of the care plan interventions. During an observation and interview on 5/24/22, 6:47 a.m. R3 was noted to be walking independently down the hallway towards the dining area, with her red four-wheeled walker. During observation and interview on 5/26/22, at 11:20 a.m. R3 was seated in her recliner in her room. R3 was transferred to bed. RN-B changed the dressing on R3's coccyx with no complaints of pain. Left and right buttocks noted to be red with open areas, the left inner buttock middle area, measures 1.5 centimeters (cm) x 1.5 cm, distal to this is the second open area that measures 0.8 cm x 0.3 cm, and the top open area measures 0.2 cm x 0.9 cm. RN-B did not have any border foam available, she stated when their scheduler quit, she oversaw ordering the supplies and they had been out of border foam dressing for a while now. RN-B used a border gauze dressing instead. RN-B verified all 3 open areas are stage 2 pressure ulcers, and further verified she was not aware of them. RN-B stated, I would expect for dressing changes to be completed as ordered and for there to be comprehensive weekly skin assessments to include weekly measurements of wounds. Aides should be reporting skin concerns and when a residents dressing comes off. RN-B verified that R3's pressure ulcers had worsened. R4's admission record identified, an admitted [DATE], with diagnoses that included dementia without behavioral disturbance, muscle wasting and atrophy and secondary Parkinsonism. R4's quarterly MDS assessment dated [DATE], indicated that R4 had severely impaired cognition, no walking, extensive assist of 2 with toilet use, total dependence of 1 with eating, hygiene and locomotion, total dependence of 2 with transfers and bed mobility, uses wheelchair for mobility. Also noted to be frequently incontinent of bowel and bladder. Section M indicated at risk for pressure ulcers, no skin concerns, has pressure reducing device for her chair and bed. Applications of ointments/medications other than to feet. R4's medical doctor (MD) orders indicated the following: 7/9/20, turn and reposition patient every 2-3 hours during the day and night. 5/11/22, cleanse wound on coccyx with NS, pat dry. Apply hydrogel to wound, 3M barrier spray around wound, let dry then cover with Mepilex border dressing and change every 2-3 days and as needed. Initial and date dressing. R4's care plan dated 1/11/19, indicated she was skin integrity risk related to impaired mobility, cognition, diabetes and incontinence. Interventions included barrier cream to buttocks as needed, encourage to reposition as needed, float heel s as able, observe skin condition with cares daily, pressure device on bed and chair, skin care routinely twice a day. Does not identify pressure ulcer. R4's Care Sheet lacks pressure ulcer interventions as MD ordered, to reposition every 2 hours and not lay R4 in supine position. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R4's NP progress note dated 4/28/22, identified R4's pressure injury of sacral region stage 2 measurements were 1.2 cm x 0.7 cm. New order: cleanse wound with NS, pat dry entirely, apply hydrogel to wound, 3M barrier spray around wound, let dry then cover with Mepilex border dressing and change every 2-3 days and as needed. Ensure R3 was not resting in supine position, assist her to position from side to side. R4's progress note dated 5/7/22, identified that Trained Medication Aide (TMA) reported that there was an open area on R4's coccyx. Area cleansed, barrier cream applied and R4 was repositioned. No apparent discomfort noted. R4's NP progress note dated 5/9/22, identified R4 was evaluated for an open area to her coccyx. Wound on R4's coccyx seems superficial and is beefy red. Pressure injury of sacral region stage 2. Measurements are 2 cm x 0.5 cm. New order: cleanse wound with NS, pat dry entirely, cover with foam border dressing (Mepilex border), initial and date dressing, and change every 3 days and as needed. Ensure R3 was not resting in supine position, assist her to position from side to side. R4's TAR dated May 2022, indicated on 5/11/22, to cleanse coccyx wound with NS, pat dry entirely, apply hydrogel to wound, 3M barrier spray around wound, let dry then cover with Mepilex border dressing and change every day shift every 3 days. R4's weekly skin review, dated 4/1/22, 4/7/22, 4/14/22, 4/28/22, and 5/21/22, all indicated no skin impairments. R4's record did not include comprehensive skin assessments completed by licensed staff. Review of R3's record also did not identify root cause of the skin break During continuous observation on 5/24/22, at 6:55 a.m. R4 was seated up to the table in the dining room holding red tubular anticontracture cushion in both hands. At 8:22 a.m. the director of nursing (DON) started to assist feeding R4. At: 8:44 a.m. R4 was done eating and continued to be seated up to the table in the dining room. During observation and interview on 5/24/22, at 9:10 a.m. NA-C and NP-A assist R4 to bed with the sit to stand lift. R4's brief was wet and removed, border dressing on coccyx area was dated 5/20/22, NP-A removed the dressing. Coccyx open area was measured 0.7 cm x 0.7 cm. NP-A verified the pressure ulcer is a stage 2, stated the order for the dressing was to change every 3 days and will need to be changed to every other day with the same treatment order. RN-B began cleansing wound with NS, R4 began to have a bowel movement. RN-B left the room and asked NA-C to let her know when she was done. At 9:32 a.m. RN-B back in the room, was not observed to wash her hands, applied gloves, cleansed wound with NS, applied hydrogel with a Qtip, and sprayed skin protect around the wound, allowed to dry, and applied 6 x 6 border gauze. RN-B stated she would normally use border foam as ordered but stated they were out of border foam in the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During interview on 5/24/22, at 9:48 a.m. RN-B stated RN-A put in her notice a couple weeks ago, she used to be the third-floor unit manager. RN-B verified that R4's dressing was dated 5/20/22, and verified it should have been changed yesterday on 5/23/22, per MD orders. After RN-A left they have been super short staffed, and stated, I think the measurements for all the wounds up here have kind of fallen off the board. I think the last time her wound was measured was May 3rd, it started out with MASD and now has turned into a stage 2. Wound measurements should be done weekly to determine if the treatment plan is effective. During observation and interview on 5/26/22, at 10:10 a.m. R4 was transferred to the toilet with the EZ-stand, there was no dressing noted on her coccyx area. RN-B measured her wound which measured 1.2 cm x 0.5 cm. RN-B verified it is a stage 2 pressure ulcer. RN-B washed wound with NS, hydrogel to wound, and skin prep around wound applied, used a 6 x 6 border gauze as the facility is still out of the foam dressings. Stated she would normally use the 4 x 4 size. RN-B verified R4's wound had worsened. R11's admission record identified an admitted [DATE], with diagnoses that included COVID-19, respiratory failure with hypercapnia, muscle weakness, cerebral infarction, dementia with Lewy bodies, and hallucinations. R11's PPS 5-day MDS assessment dated [DATE], indicated that R11 had severely impaired cognition, no walking, required supervision with eating and locomotion, extensive assist of one with locomotion and extensive assist of 2 with bed mobility, transfers, dressing, toilet use and hygiene, used wheelchair for mobility. Always incontinent of bowel and bladder. Identified that R11 is at risk for pressure ulcers, no current skin concerns. Pressure reducing device for bed and chair and application of ointment/medication other than to feet. R11's NP progress note dated 5/12/22, did not identify any skin issues to her buttocks. R11's NP progress note dated 5/16/22, follow up for incontinence associated dermatitis (a type of MASD). R11 complained of pain/discomfort in her groin and intergluteal area, stated it was from her ongoing diarrhea. Nursing reported R11's bottom is raw or sore. Appearance appeared so raw and erythema (red). Current plan, cleanse patient after each incontinence and apply barrier cream, apply hydrocortisone (corticosteroid) cream and clotrimazole (antifungal cream) twice daily. R11's NP progress note dated 5/20/22, identified a visit for COVID infection, no new orders, diarrhea resolved 2 days ago, and skin was not assessed. Projected date of R11 coming out of isolation was 5/28/22. R11's NP progress note dated 5/23/22, identified a follow up visit for COVID infection, identified a pressure ulcer of sacral region measuring 2 cm x 0.5 cm, open area has good granulation tissue, new order for sacral dressing, cleanse with NS, pat dry entirely, apply hydrogel to wound, 3M barrier spray around wound, let dry then cover with Mepilex border dressing and change every day. Initial and date wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R11's care plan prior to 5/26/22, lacked a focus, goal and interventions pertaining to skin concerns. On 5/26/22, indicated R3 has actual skin integrity break and/or pressure sore, chronic non pressure wound on buttock, interventions assess and measure all skin integrity areas per policy, monitor and report any new open areas, draining, or pain to nurse immediately, provide treatment to wound per current treatment order. Interventions do not include, repositioning or offloading pressure ulcers per current NP orders. Toileting assist was not addressed. R11's SBAR (situation, background, assessment, response) progress note dated 5/26/22, at 2:43 p.m. R11 noted to have an open area on her sacrum that measure 2.2 cm x 0.9 cm and an open area on her right buttock that measures 1.1 cm x 0.6 cm. These are both superficial open areas. Surrounding skin does look red and irritated. Areas cleaned with NS and foam and bordered gauze applied for protection. R11's medical record lacked weekly skin assessment nor include comprehensive skin assessments completed by licensed staff. Review of R3's record also did not identify root cause of the skin break down nor an assessment/evaluation of the effectiveness of the care plan interventions. R11's care sheet was requested and not provided. R11's TAR requested and not provided. During interview on 5/26/22, at 10:13 am NA-E was in R11's room and stated R11 had a bowel movement, so her dressing got soiled and it was thrown away. NA-E stated R41 does have a small crack in her butt crease. RN-B stated there were no current dressing orders for R11. During observation on 5/26/22 10:18 am. RN-B helped assist R11 to her left side while in her bed. RN-B cleaned gluteal cleft with NS. RN-B verified R11 has a stage 2 pressure ulcer on right side of buttock near fold that measures 1.1 cm x 0.6 cm, sacral wound is 2.2 cm x 0.9 cm, and small area of excoriation on left buttock. RN-B stated, I will put a gauze dressing on it for right now to cover the area and will call MD and get an order for a dressing. During interview on 5/26/22, 10:20 a.m. RN-B stated, I would expect to do doing dressing changes as ordered and for there to be weekly skin assessments. Aides should be reporting when dressings come off. RN-B verified the pressure ulcer had worsened. R41's admission record identified an admitted [DATE], with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, unilateral primary osteoarthritis of left knee and anxiety disorder. R41' s admission MDS assessment dated [DATE], indicated that R41 had severely impaired cognitive impairment, physical and verbal behaviors occurred for 4 to 6 days and displayed other behavioral symptoms not directed towards others for 1 to 3 days. R41 did not walk, required extensive assist of 1 with hygiene, extensive assist of 2 with toilet use, dressing, transfers and bed mobility and total dependence of 1 with locomotion and eating. R36 was always incontinent of bladder and bowel and no pressure ulcers identified. At risk for pressure ulcers, pressure reducing device for bed and wheelchair, application of nonsurgical dressing and ointment/medications other than to feet. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R41's MD progress note dated 5/4/22, identified that R41 had slept the night in his Geri chair (a large, padded chair that is cushioned and can recline, that is designed to help seniors with limited mobility). R41's progress note dated 5/9/22, indicated R41 had V-shaped redness to his buttocks, no measurement identified, barrier cream and nystatin powder applied and covered with a Mepilex dressing. R41's NP progress note dated 5/10/22, identified that R41's wife had concerns about R41 getting pressure ulcers due to all the time spent in his Geri chair. Pressure ulcer stage 1 of sacral region was noted with a picture. Did not identify a measurement. New order to apply 3M barrier spray to skin, air dry and cover with a Mepilex border. Change dressing every 3 days and as needed if soiled. Initiate frequent positioning, at least every 2 hours. Ensure to lay down after breakfast and lunch to offload pressure. R41's care plan dated 5/16/22, identified R41 at risk for skin integrity condition or pressure ulcers, related to impaired mobility, incontinence of bowel and bladder, and nutritional deficit-malnutrition. Interventions included: frequent repositioning, pressure reduction chair cushion and pressure reduction mattress, avoid friction/shearing while repositioning and keep resident clean and dry use barrier cream after good peri-care, also apply proper incontinent products as indicated. apply dressing to area as needed. Further identified R41 to be dependent on staff for toileting and to offer toileting upon rising, before and after meals, activities and at bedtime. R41's progress note dated 5/21/22, at 6:24 a.m. indicated R41 slept all night in his Geri chair. R41's progress note, SBAR dated 5/26/22, at 2:11 p.m. indicated R41 had his dressing changed to his buttocks and a superficial open area measuring 1.8 cm x 0.7 cm just to the left of his sacrum. Skin surrounding the open area was red but was blanchable. Area cleansed with NS, foam dressing and bordered gauze applied, please assess and determine if new orders need to be initiated for this new finding. R41's weekly skin review assessments were completed on 5/4/22, 5/18/25 and 5/24/22, and indicated no skin concerns. Review of R3's record also did not identify root cause of the skin break down nor an assessment/evaluation of the effectiveness of the care plan interventions. During continuous observation on 5/24/22, 6:55 a.m. R44 was noted to be well groomed and dressed seated up to the table for breakfast. At 7:52 a.m. R41 remained seated in his Geri chair in the dining room near the window. At 8:22 a.m. the DON noted to be assisting R41 with eating. At 8:44 a.m. R41 continued to be seated up to the table in the dining room overlooking the window. At 9:45 a.m. R41 remained seated in the same spot looking out the window. At 10:33 a.m. R41 remained in the dining room in his Geri chair, no one had offered to reposition or toilet R41. Toileting and repositioning record indicate he was toileted and repositioned on 5/24/22, at 5:59 a.m. and again at 12:17 p.m. 6 hours without being offered toileting or repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During interview on 5/24/22, at 7:06 a.m. NA-C stated, We are severely short staffed, I don't get to reposition the residents or potty them timely. For example, R41 came here about three weeks ago, by Monday he already had a sore on his bottom that opened up, he literally sits in that chair all the time. During observation on 5/26/22, at 8:54 a.m. R41 was noted to be seated in his Geri chair in the dining room with his breakfast tray in front of him. During observation and interview on 5/26/22, at 11:08 a.m. NA-E and NA-J assisted R41 to the toilet via ez-stand, RN-B assessed R41's buttocks and noted an open area measuring 1.8 cm x 0.7 cm just to the left of his sacrum. RN-B verified this was a stage 2 pressure ulcer. Skin surrounding the open area was red but blanchable. Area cleansed with NS, foam dressing and bordered gauze applied. RN-B stated she would contact the doctor for dressing order, stated she was not aware he had a pressure ulcer and verified the last mention of his wound to buttocks was reddened on 5/9/2,2 and verified his wound had worsened. During interview on 5/26/22, at 11:20 a.m. NA-J verified R41 had not been offered toileting or repositioning since he got up in his chair at 5:39 a.m. R43's admission record identified an admitted [DATE], with diagnoses that included Paranoid schizophrenia, dementia with behavioral disturbance, left knee arthritis and cervicalgia. R43's quarterly MDS assessment dated [DATE], indicated that R43 had moderately impaired cognition, no walking, supervision with eating, extensive assist of 1 with locomotion and extensive assist of 2 with toilet use, hygiene, dressing, transfer and bed mobility, uses wheelchair for mobility. Also noted to be frequently incontinent of bowel and bladder and no pressure ulcers identified. At risk for pressure ulcers, pressure reducing device for bed and wheelchair, application of nonsurgical dressing and ointment/medications other than to feet. R43's MD orders dated 5/7/22, indicated to apply Mepilex to coccyx area every day to prevent skin break down. Offload from chair every 3 hours document refusal. R43's MD notes were asked for and not provided. R43's care plan dated 6/21/17, identified R43 is at risk for skin integrity break related to impaired mobility, and bowel and bladder incontinence. Interventions included to lay resident down in bed after meals to offload buttocks, provide treatment to wound per current treatment order, assess and observe wounds for signs and symptoms of infection with each dressing change, report negative findings to the physician. For toileting provide incontinence care/perineal care after each incontinent episode. Use barrier cream each time. April 2022 skin assessments were completed weekly and identified no skin concerns R43's weekly skin assessments dated 5/3/22, identified a pink coccyx-barrier cream applied. On 5/10/22, assessment showed reddened coccyx applied barrier cream, 5/17/22 and 5/25/22 skin assessments do not identify any skin concerns. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R43's TAR dated 5/10/22, indicated an order to apply Mepilex to coccyx area every day to prevent skin break down every evening shift every 3 days. Offload from chair every 3 hours document refusal. R43's toileting and repositioning documentation was reviewed for 5/24/22, and was noted to have assist at 5:59 a.m. 1:59 p.m. and 9:58 p.m. During observation on 5/24/22, at 6:47 a.m. R43 was noted to be seated up to the table in the dining room. At 10:33 a.m. remained seated in the dining room was not offered toileting or repositioning during this period of time. During interview on 5/24/22, at 7:06 a.m. NA-C stated, We are severely short staffed, I don't get to reposition the residents or potty them timely. For example, we have lots of pressure ulcers on this unit within the last few weeks that just happened because we have been running such short staffed. There are four residents that I can think of [R3, R4, R41 and R42]. It is from not enough staff so we can't reposition them, toilet timely, several are two person transfers, and they are all incontinent. During observation on 5/26/22, at 10:41 am. R43 was transferred to the toilet with an ez-stand, a bordered foam dressing dated 5/14/22, was found on her lower back, underneath dressing skin was clean and intact on lower back. RN-B was not sure why the dressing was there and verified there were no orders for it. RN-B assessed buttocks and found a stage 2 pressure ulcer that measured 0.4 cm x 0.2 cm, verified it is stage 2 pressure ulcer and stated, I will put some zinc cream on it and write up an sbar for the doctor so we can get a dressing ordered. During interview on 5/26/22, at 4:01 p.m. DON was asked when R41's first skin issue was and DON was not aware of one. When told DON that R41 had a 1.8 cm x 0.7 cm, stage 2 pressure ulcer to left upper buttock that RN-B verified and measured. DON stated, Our company says we are not allowed to stage a pressure ulcer, we are to notify the provider and they are the ones that will diagnose it. DON could not find any pressure ulcer in the medical record, when asked about R3, R4, R11, R42 and R43, stated she will have to check. DON was notified that there were continuous observations done on 5/24/22, for R4, R41, and R42 and they were not moved out of their wheelchairs for almost 4 hours, not offloaded, toileted, or repositioned. DON stated her expectation is to offer toileting, repositioned and offloaded per the care plan, especially when they are at risk for pressure ulcers. DON stated they have been short staffed since RN-A abruptly quit. When asked who took over the unit manager for 3rd floor, DON stated, well me and RN-B are trying to. During interview on 5/27/22, at 11:08 a.m. DON indicated the facility has been severely short staffed. DON stated when RN-A (who was the third-floor unit manager) quit on 5/6/22, was when the staffing got bad. DON stated, We have no maintenance staff, no social worker, no unit manager for third floor, no scheduler, and our MDS coordinator is out with COVID, so I am having to fill it all. DON verified they have not hired a replacement for third floor manager and verified no one has been doing the third-floor managers job which includes the RN assessments, falls, wound assessments, and care plan updating. R42's admission record identified, an admitted [DATE], with diagnoses that included Alzheimer's disease, dementia, and spinal stenosis. (continued on next page)

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Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R42's quarterly MDS assessment dated [DATE], indicated that R42 had severely impaired cognition, no walking, extensive assist of one staff with dressing, extensive assist of 2 staff with bed mobility, total dependence of 1 staff with locomotion, hygiene and eating, total dependence of 2 with transfers, uses wheelchair for mobility. R42 was frequently incontinent of bladder and bowel and no pressure ulcers identified. At risk for pressure ulcers, pressure reducing device for bed and wheelchair, application of nonsurgical dressing and ointment/medications other than to feet. R42's NP progress note dated 5/6/22, identified new wound measurements from 4/29/22, were 0.7 cm x 0.5 cm x 0.1 cm to intergluteal cleft. Current measurements are 2.1 cm x 1 cm x 1 cm and distal pinpoint 0.3 cm 0.3cm open area. New order Intergluteal Cleft, cleanse with normal saline or wound cleanser. Pat dry and apply Hydrogel to open areas and then 3 M barrier spray to surrounding skin, then cover with foam border dressing. Initial and date dressing. Change every other day and PRN when soiled. Ensure skin is always dry. Ensure patient is repositioned every 2 hours to offload pressure. R42's NP progress note dated 5/13/22, identified wound measurements 2.1 cm x 1 cm x 1 cm and distal pinpoint 0.3 cm 0.3cm open area. New order Intergluteal Cleft, cleanse with normal saline or wound cleanser. Pat dry and apply Hydrogel to open areas and then 3 M barrier spray to surrounding skin, then cover with foam border dressing. Initial and date dressing. Change every other day and PRN when soiled. Ensure skin is always dry. Ensure patient is repositioned every 2 hours to offload pressure. R42's MD Orders dated 5/13/22, indicated, Intergluteal Cleft, cleanse with normal saline or wound cleanser. Pat dry and apply Hydrogel to open areas and then 3 M barrier spray to surrounding skin, then cover with foam border dressing. Initial and date dressing. Change every other day and PRN when soiled. Ensure skin is always dry. R42's NP progress note dated 5/23/22, identified wound measurements from 4/29/22 were 0.7 cm x 0.5 cm x 0.1 cm to intergluteal cleft and 2.1 cm x 1 cm x 1 cm and distal pinpoint 0.3 cm 0.3cm open area. Continue with current orders and will follow up in 1 week on 6/1/22. R42's care plan reviewed and indicated the potential for developing skin alterations due to resistance with bathing and cares from caregivers, often refuses baths and will refuse am and pm cares, interventions included Inform the resident/family/caregivers of any new area of skin breakdown, monitor dressing to ensure it is intact and adhering. Report lose dressing to Treatment nurse, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. For toileting the intervention is to check resident before and after meals and prn for incontinent episodes. R42's Care sheet identified R42 needed mechanical assist of 2 with transfers and did not identify repositioning and pressure ulcers. Toileting should be offered every am and hs and before and after meals. During observation on 5/24/22, at 6:47 a.m. R42 was noted to be seated up to the table in the dining room. During observation on 5/26/22, at 8:06 a.m. R42 was seated in her Broda chair up to the table in the dining room. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During observation on 5/26/22, at 8:54 a.m. R42 was seated in her Broda chair dressed in blue, has a blanket on her lap, with mask on and her eyes closed, she is seated up to the table. During observation and interview on 5/26/22, at 9:33 a.m. R42 is transferred to the toilet with EZ-stand, R42 is noted to not have a dressing on her buttocks. RN-B measures the wound 0.3 [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to ensure fall program protocols were implemented resulting in system failure. The system failures included, failing to ensure completed comprehensive assessments, identification of causal factors and probable root cause, and development and implementation of interventions that would prevent and/or mitigate the risk of re-current falls and injury. In addition, the facility failed to complete post-fall neurological assessments in accordance with the facility's policy and failed to ensure interdisciplinary involvement process for 6 of 6 residents (R33, R36, R3, R1, R24, R41) reviewed for falls. This had the potential to affect all residents who are at risk for falls residing in the facility. Finding include R33's admission record identified diagnoses that included Alzheimer's disease, dementia, seizures, wedge compression fracture of first lumbar, and unspecified sensorineural hearing loss. R33's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated that R33 had moderately impaired cognition, required supervision with eating, extensive assist of one staff with dressing, hygiene, bed mobility, transfers, toileting, and walking, and used a walker and wheelchair for mobility. Also noted to be occasionally incontinent of bladder and frequently incontinent of bowel, had two or more falls with no injury. Prior quarterly MDS assessment dated [DATE], identified two or more falls with no injury. R33's care plan dated, 7/15/21, identified R33 was at risk for falls due to history of falls and confusion. Interventions included, anti-tip/rollback breaks applied to wheelchair, encourage to transfer and change positions slowly, have commonly used articles in reach, provide assist to transfer and ambulate as needed, reinforce need to call for assist, reinforce wheelchair safety as needed such as locking breaks, and wheelchair for distance. Most recent intervention was on 2/4/22, was staff to assist R33 with closing the door to his room. Care plan further identified that R33 needed assist with daily hygiene, grooming, dressing, oral care and eating as needed, and required one staff assist with transfers, walking and toileting. R33's fall records were reviewed between 5/10/22, to 5/27/22, the record identified R33 had five unwitnessed falls; three of the five fall records identified R33 was attempting to use the bathroom. R33's record indicated although constantly identified predisposing risk factors, the record consistently lacked a comprehensive fall assessment to determine root cause for appropriate interventions or failed to include appropriate interventions when the root cause was identified. In addition, the record also lacked evidence neurological assessments were completed after the fall to rule out head injury in accordance with facility policy and their was no evidence of interdisciplinary involvement or process. Fall 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's progress note dated 5/11/22, indicated R33 had an unwitnessed fall, had slid down from his recliner, both his arms support his body, his legs straight in seated position, no injuries and denied pain, vitals and range of motion (ROM) done. Corresponding incident report identified the fall occurred at 9:00 a.m., predisposing factors identified as confusion, and immediate action taken included vital signs and ROM (range of motion) completed. R33's Post fall assessment dated [DATE], identified R33 had multiple falls within the last month; a pattern or trend was not identified. The assessment did not identify a root cause however had the intervention of R33's wheelchair breaks locked, and a referral was made therapy and maintenance. The record did not identify the purpose of the maintenance referral for the locked wheelchair breaks as the documentation R33 had slid out of his recliner. R33's care plan did not reflect revision. Fall 2 R33's incident report dated, 5/13/22, indicated R33 had an unwitnessed fall, an unknown aide alerted the nurse that he had heard a loud crash was unable to get into R33's room but did get in through an adjoining bathroom where R33 was found sitting on the floor with his back to the door. R33 was asked if he was trying to go to the bathroom and he stated, yes. When asked if he hit head, he said he didn't remember. Immediate action taken was R33 was safely assisted from the floor, vital signs within normal limits (WNL), head to toe assessment done and neuro checks started. Predisposing factors were poor lighting, weakness, gait imbalance, was ambulating without assist, transferring self and using walker. R33's Post fall assessment dated [DATE], identified the fall occurred at 3:00 a.m. R33 has had 1-2 falls within the last month and last 3 months, multiple falls in the last 6 months; the record include analysis for pattern or trend. The assessment further indicated R33 was trying to get to the bathroom and was last seen at 2:15 a.m. in bed. R33 was confused some of the time before the fall. The new intervention was re-education to use the call light for assist. The record lacked evaluation of R33's ability and/or memory to use the call light for assistance since the care plan prior to the fall had already identified reinforce need to call for assist. Fall 3 R33's incident report dated, 5/13/22, indicated, R33 had an unwitnessed fall, R33 stated he was looking for clothes to wear and was found on the floor in his room next to his closet, with his walker close by. The Immediate action that was taken was R33 was assisted off the floor, no complaints of pain with ROM, and R33 was assisted with cares and helped into his wheelchair. Predisposing factors were confusion, gait imbalance, and was looking for something. The record did not include a post fall assessment, lacked identification of root cause, neurological assessments, and the care plan did not reflect revision. Fall 4 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's incident report dated, 5/14/22, at 5:45 a.m., indicated that R33 had an unwitnessed fall, his roommate R36 was yelling for help. When staff entered the room, R33 was noted to be sitting on the floor with his back against the bed and facing the bathroom. R33 stated, I got up to go to the bathroom, I slid and fell . R33 was assessed for injuries and noted to have a skin tear on the back of his left elbow that measured 1 centimeter (CM) x 0.5 cm, area was cleansed with normal saline (NS). R33 was alert to self and situation, vital signs completed and neuro checks implemented to be wnl (within normal limits). R33 was transferred to bed with assist of two and a mechanical lift. Predisposing factors were impaired memory and was ambulating without assist. R33's record did not include a post fall assessment. Even though the report identified probable root cause was R33 was attempting to use the bathroom, the record did reflect a comprehensive bladder assessment or evaluation/revision to the toileting care plan. Fall 5 R33's incident report dated, 5/27/22, at 4:15 p.m., indicated a nursing assistant found R33 on the floor in his bathroom, no injury noted. Predisposing factors were impaired memory, confusion, and was he was ambulating without assist. The record did not include a post fall assessment. Even though the report again indicated R33 was found attempting to use the bathroom, the record did not include a bladder assessment or care plan evaluation/revision to R33's toileting plan. During interview on 5/24/22, at 7:06 a.m. NA-C stated, we are severely short staffed, I don't get to reposition the residents or potty them timely. R33 falls a lot, there is nothing that I know of that they put in place to prevent falls for him. During observation on 5/24/22, at 8:15 a.m. R33 noted to be lying bed with it low to the ground and was coughing, has contact precaution signs on his door and a PPE cart outside his room, door to his room is open R36's admission record identified R36 had diagnoses that included diffuse traumatic brain injury (TBI) with loss of consciousness for a specified duration, dementia and syncope and collapse. R36's quarterly MDS assessment dated [DATE], indicated that R36 had moderately impaired cognitive impairment, physical and verbal behaviors for 1 to 3 days. R36 required supervision with eating, did not walk, total dependence of 2 with transfers and extensive assist of 2 staff with dressing, hygiene, bed mobility, and toileting, and used a wheelchair for mobility. R36 was always incontinent of bladder and bowel and had 1 fall with no injury. R36's care plan revised on 1/28/22, identified R36 was at risk for falls related to cognition, unaware of safety needs, gait balance problems, and history of falls. Interventions included, call don't fall sign, wear appropriate footwear, refer to medical doctor (MD) for follow up regarding fall and hypotension, and have call light in reach. Most recent intervention was on 4/26/22, was air mattress to remain in static mode. The care plan also identified R33 required one staff assist with transfers and did not identify R36's level of assistance for toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R36's care sheet (abbreviated care plan aide used by direct care staff) indicated R36's fall interventions included air mattress to remain in static mode and call don't fall sign. R36's record was reviewed between 4/15/22, to 5/26/22, the record revealed R36 had fallen out of bed four times and found between the bed and the wall. R36's record although consistently identified R36's predisposing risk factors the record consistently lacked a comprehensive fall assessment/analysis of the risk factors for determination of root cause in order to develop and implement immediate appropriate interventions to prevent and/or mitigate R36's risk for falls. In addition, the record also lacked evidence neurological assessments were completed after the fall to rule out head injury in accordance with facility policy. Furthermore, there was no evidence of interdisciplinary involvement or process. Fall 1 R36's progress note dated 4/26/22, at 5:23 a.m. indicated R36 had an unwitnessed fall, he was found between the bed and the wall; R36 had denied pain and no injuries were noted. The note also included that R36's air mattress was off and indicated the intervention was to check the mattress. The corresponding incident report identified predisposing factors were impaired memory, weakness, transferred self, and the air mattress was off. Fall 2 R36's incident report dated 5/9/22, indicated R36 had an unwitnessed fall at 7:00 p.m., he was found between the bed and the wall with the bed in low position. (R36's medical record did not identify this fall had occurred.) Predisposing factors identified as impaired memory and weakness. The status of the air mattress was not identified. Fall 3 R36's progress note dated 5/9/22, indicated R36 was found on the floor between the air mattress and his bed, no injury was noted. The corresponding incident report dated 5/9/22, at 10:34 p.m. identified R36's fall as per the aforementioned progress note and included R36's bed was in low position. R36's predisposing risk factors were impaired memory and weakness. Fall 4 R36's progress note dated 5/26/22, at 10:14 p.m. indicated that R36 was found stuck in between the bed and wall, R36 stated he hit his head lightly. During observation on 5/24/22, at 8:15 am, R36 was noted to be dressed and lying on his left side with the bed in lowest position. R3 R3's admission record identified R3 had diagnoses that included repeated falls, neurocognitive disorder due to vascular dementia with behavioral disturbance, bilateral hearing loss, expressive aphasia, and history of left femur fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's discharge MDS assessment dated [DATE], indicated 2 or more falls with no injury. R3's quarterly MDS assessment dated [DATE], indicated that R3 had moderately impaired cognition, required supervision with eating and locomotion, extensive assist of one staff with all other activities of daily living, (ADL)'s, and used a walker and wheelchair for mobility. Also noted to be frequently incontinent of bladder, always incontinent of bowel, no falls and received anticoagulants. R3's MD note dated 5/3/22, identified R5 has a history of falls and received apixaban (blood thinner) for a history of pulmonary embolism. R3's care plan dated, 9/16/20, identified R3 was at risk for falls related to cognition, unaware of safety needs and gait balance problems. Interventions included ensure appropriate footwear, have call light within reach, educate on fall prevention measures, and complete seated/standing exercises 1-2 times daily assist of one is required. Most recent intervention was on 3/7/22, which directed staff to follow therapy recommendations. The care plan dated 3/7/22 also identified R3 slid from recliner to floor. Care plan further identified that R3 needed assist with daily hygiene, grooming, dressing, oral care and eating as needed and required 1 assist with transfers. R3's progress note dated 4/22/22 at 7:27 p.m., indicated, R3 had an unwitnessed fall on 4/22/22, at 3:10 p. m. was found in her room near the entrance of the door. Nurse to educate R3 to use her call light when getting up from recliner, she was non-compliant with mobility issues and will have one assist with ambulation. The corresponding incident report identified the fall as per the progress note. The report indicated R3 was trying to crawl back to her recliner. The report identified R3's predisposing risk factors were gait imbalance, impaired memory, weakness, was reaching for something, and transferring self. R3's post fall assessment dated [DATE], identified R3 has had multiple falls within the last month, last three months and last six months. Identified 1 fracture related to fall in the last 6 months. The assessment indicated R3 had stated she was looking/reaching for something; assessment of what R3 was looking/reaching for was not identified. The assessment also included that R3 was last seen at 3:00 p.m.; no other information was documented. Although the record identified predisposing risk factors, the record lacked a comprehensive fall assessment for determination of root cause in order to develop and implement appropriate interventions to prevent and/or mitigate R36's risk for falls. In addition, the record also lacked evidence neurological assessments were completed after the fall to rule out head injury in accordance with facility policy. During an observation and interview on 5/24/22 6:47 a.m., R3 walked independently down the hallway towards the dining area, with her red four-wheeled walker. While ambulating R3 was hunched over, and her gait was not steady. NA-C stated that R3 fell and fractured her hip awhile back, after that she needed more assist. NA-C verified R3 was to be stand by assist with the use of a gait belt when ambulating. NA-C stated, we just don't have enough staff to do that with her, as you can see, she just gets up and goes wherever she wants, we just don't have the staff, and she has fallen several times since her surgery. When asked what the prevention interventions were to keep R3 from falling NA-C stated, they haven't done anything different to keep her from falling that I am aware of, and this is the main unit I work on fulltime. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 5/24/22, at 8:06 a.m. R3 stood up from the chair and started walking unassisted out of the dining room and down the hall with her wheeled walker. At 8:13 a.m. R3 was seated in her wheeled walker in her room, eating her breakfast. At 8:14 a.m. R3 noted to get up and walk with an unsteady gait from her room towards the dining room with no assist. At 8:22 a.m. R3 was walking unassisted around the unit with an unsteady gait. Staff did not intervene and were observed helping other residents eat in the dining area. At 8:45 a.m. R3 was seated in her wheeled walker in her room in front of the television. R1's admission Face Sheet indicated R1 had medical diagnoses that include muscle weakness, abnormalities of gait and mobility, and unsteadiness on feet. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had severe cognitive impairment and required extensive staff assistance with bed mobility, transferring, locomotion, dressing, toileting and personal hygiene. R1's Care Plan, printed 5/27/22, identified R1 as at risk for falls related to gait balance problems and history of falls. Fall prevention interventions dated 7/13/21, included anticipate and meet the resident's needs; encourage R1 to always call for assistance; educate R1 on fall prevention measures; assure R1 that calling for help is not a bother; encourage R1 to change positions slowly and allow time to get her bearings before standing; ensure the R1 is wearing appropriate footwear-shoes; place call light within reach and promptly answer; and R1 requires assistance with her four-wheel walker while ambulating. The most recent interventions included: - complete rounds at least every two hours and offer toileting, ask about any needs, and remind R1 to use the call light to obtain assistance (start date 9/21/21) -Bilateral assist bars to R1's bed to aid in repositioning (start date 2/17/22) -Place frequently used items within reach, place scoop mattress on her bed, and to follow therapy recommendations for transfers, mobility and ambulation. (Start date 3/2/22) R1's most recent fall risk assessment dated [DATE], indicated R1 was at moderate fall risk. Review of the incident reports identified R1 experienced falls one fall on 5/11/22 and two falls on 5/21/22. R1's records lacked comprehensive assessments, did not identify root cause, and there was not evidence the care plan had been reviewed/revised with fall prevention interventions. Incident report dated 5/11/22, at 11:08 p.m. R1 was found uninjured on the floor in her room. R1 stated she slipped off the chair. Incident report dated 5/21/22, at 2:00 p.m. R1 was found uninjured her fall mat next to her bed. R1 stated she does not know what happened. Incident report dated 5/21/22, at 7:00 p.m. R1 was found uninjured on the floor in her room. R1 states she does not know what happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/22, at 10:35 a.m. R1 stated she has had falls but was trying to remember to use her call light. R1 indicated she needs help to get to the bathroom but when staff are slow to respond to her call light, she tries to go by herself. R1 stated if she waits too long, she urinates in her depends. R24's Face Sheet indicated R24 had diagnoses that included unsteadiness on feet, frontal lobe and executive function deficit, abnormalities of gait and mobility, and dementia. R24's quarterly MDS assessment dated [DATE], indicated R24 was unable to complete the BIMS assessment indicating severe cognition deficient and required extensive assistance with bed mobility, transferring, locomotion, dressing, toileting and personal hygiene. R24's Care Plan directed on 7/19/21, that R24 has a history of falls, anticipate and meet R24's needs, encourage R24 to always call for assistance, place call light within reach and answer promptly; educate R24 on fall prevention measures; assure R24 that calling for help is not a bother; ensure R24 is wearing appropriate footwear; and follow therapy recommendations for transfers, mobility and ambulation. On 11/11/21, R24's care plan was updated to include directing staff to place a call don't fall sign in R24's room and to remind resident to ask for assistance, and to place a scoop mattress on her bed. Lastly, on 12/19/21, R24's Care Plan directed staff to place R24's bed in lowest position. Review of R24's fall incident reports identified R24 had three falls between 5/1/22 and 5/24/22, the record lacked a comprehensive fall assessment, lacked identification of probable root cause, and did not include review/revision of the care plan. Incident Report dated 5/11/22, at 11:08 p.m. R24 was found uninjured on the floor. R24 stated she slipped off the chair and fell to the floor. R24's 5/11/22 post fall Assessment indicated R24 was at low risk for falls, however, the assessment identified R24 was at risk for falls related to gait balance problems and had a history of multiple falls. Incident report dated 5/21/22, at 2:00 p.m. R24 was found uninjured on the floor and indicated she fell on to fall mat. Resident stated she does not know what happened. Incident report dated 5/21/22, at 7:00 p.m. R24 was found uninjured on the floor. R24 states she does not know what happened. R41's admission record identified, an admitted [DATE], with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, unilateral primary osteoarthritis of left knee and anxiety disorder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R41's admission MDS assessment dated [DATE], indicated that R41 had severely impaired cognitive impairment, physical and verbal behaviors occurred for 4 to 6 days and displayed other behavioral symptoms not directed towards others for 1 to 3 days. R41 did not walk, required extensive assist of 1 with hygiene, extensive assist of 2 with toilet use, dressing, transfers and bed mobility and total dependence of 1 with locomotion and eating. R41 was always incontinent of bladder and bowel and had a fall 1 month prior to admit and a fall 2 to 6 months prior to admit. R41's provider note dated 5/13/22, that R41 was found on the fall mat next to his bed at 6:30 a.m. will continue with fall precautions per facility's protocol. R41's care plan dated on 5/16/22, identified R41 was at risk for falls related to cognition-unaware of safety needs, dementia, weakness, gait balance problems, history of falls, incontinence, pain and medications. Interventions included, have call light in reach, encourage to call for assist, lipped mattress on bed, and bed in lowest position. Care plan further identified that R41 was dependent with daily hygiene, grooming, dressing, oral care and eating, and transfer with a sit to stand lift, does not identify assist level with toileting. Toileting to be offered upon rising, at bedtime and before and after meals. R41's progress note dated 5/13/22, at 6:30 a.m. indicated that when staff were walking by R41's room, he was noted to not be in bed and was found on the floor at the foot of his bed, he could not say how he got there, used mechanical lift to get up off the floor, was assisted with cares and transferred to his Geri chair (a large, padded chair that is cushioned and can recline, that is designed to help seniors with limited mobility). The corresponding incident report included the aforementioned fall information. The incident report indicated R41's predisposing risk factors were confusion, gait imbalance, and transferring self and further identified the bed was in low position with mat on the floor. The record lacked a comprehensive fall assessment/analysis of the risk factors for determination of root cause, lacked care plan evaluation/revision, lacked evidence neurological assessments were completed and there was no evidence of interdisciplinary involvement or process. In addition, the record also lacked evidence neurological assessments were completed after the fall to rule out head injury in accordance with facility policy. Furthermore, there was no evidence of interdisciplinary involvement or process. During an interview on 5/26/22, at 7:48 a.m. nursing assistant (NA)-B stated after a resident falls, leadership reviews the fall, creates new fall prevention interventions and enters them in the Care Plan. NA-B is unsure if NA's have access to residents Care Plans and further stated NAs cannot view fall prevention interventions in the Point of Care - Kardex. NA-B indicated she would talk with a nurse to find out fall prevention interventions. NA-B further stated if a resident has a new fall prevention intervention, the nursing staff will inform NA's. When questioned how an NA who did not work for a week or if there was an agency NA, how they would know if there is a new fall prevention intervention, NA-B stated she does not know how staff would know what current fall prevention intervention are documented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/26/22, 3:37 p.m. NA-I stated if a resident falls, the nurse fills out an incident report, leadership reviews it and creates new fall prevention interventions. The new fall prevention intervention are then entered in the Care Plan. NA-I stated the Care Plan is the first and only place to look for all interventions. NA-I stated if there isn't a fall prevention intervention in the Care Plan, then the intervention does not exist. NA-I shared that staff talk about fall prevention interventions and that is how they know if a new intervention was created. During an interview on 5/26/22, 3:51 p.m. NA-J stated not knowing for sure where to look for fall prevention interventions and indicated she would ask the nurse. NA-J stated, creating fall prevention interventions is an informal process and discussed at end of shift report. NA-J was unable to articulate if an intervention is not documented in the Care Plan how an agency staff would know what interventions are or if current staff would know if a new intervention was passed along to all staff. During interview on 5/27/22, at 11:08 a.m. director of nursing (DON) indicated the facility has been severely short staffed. DON stated when RN-A (who was the third-floor unit manager) quit on 5/6/22, was when the staffing got bad. DON stated, we have no maintenance staff, no social worker, no unit manager for third floor, no scheduler, and our MDS coordinator is out with COVID, so I am having to fill it all. DON verified they have not hired a replacement for third floor manager and verified no one has been doing the third-floor managers job which includes the RN assessments, falls, wound assessments, and care plan updating. Since RN-A has left, all residents that have had falls on the third floor, their care plans have not been updated with new interventions, and their falls have not been root caused. During an interview on 5/27/22, at 12:24 p.m. director of nursing (DON) stated she, the nurse managers, or MDS Coordinator can enter fall prevention interventions into the Care Plan. This occurs after the interdisciplinary team (IDT) discusses the fall and identifies new intervention(s). The IDT meets every weekday and part of the discussion is to review fall reports from the previous day. Further, the Quality Assessment Process Improvement (QAPI) meets weekly to discuss at-risk residents, including reviewing all falls. DON admitted that due to the staffing shortage and the loss of the staffing coordinator, she is managing the staffing schedule and does not have time to get into each resident's chart to update the Care Plan. The IDT discusses fall prevention interventions, they are just not entered into the resident's chart in a timely fashion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy, Fall Prevention and Management Guidelines, revised March 10, 2021, identified that the facility will maintain a fall prevention and management program. Objective: appropriate fall management may result in reducing falls, minimizing injuries, and ultimately improving the quality of life of residents, limit and prevent the occurrence of falls within the parameters that can be controlled though the structured program interventions, minimize the severity of injuries sustained by the resident resulting from a fall, and educate the resident, family, and direct care facility staff. A. Assessments that may assist with identification of a fall risk, potential hazards, and interventions intended to prevent falls or minimize injuries: 1. Clinical assessment, will be completed by the nurse in a timely fashion, frequency of reassessment after a fall, a significant change, quarterly annually and as needed. 3. Continence Protocol as indicated, toileting schedule-implement as needed and bladder training as indicated. 4. Mental status assessment-recall assessment and judgement. 5. Pain assessment. 6. Review the resident's medical record for any diagnosis that may contribute to an increased risk with a fall or increased risk of injury should a fall occur such as: orthostatic hypotension, osteopenia, osteoporosis, history of falls, wandering, and dementia. 7. pharmacological assessment and review. 8. Environmental assessment. B. Plan of Care; 1. Specific interventions should be developed based on the results of the fall assessment and individual resident preferences: c. resident daily routines, d. mental status behaviors, e. physical limitations to include ADL's and continence. f. pain, and g. medication use. 2. As information is updated, it needs to be communicated to staff, resident and family. C. Complete a post fall evaluation and complete required notifications after every fall, near miss fall, or assisted fall. a. An investigation and fall risk assessment must be completed. Should include: 1. Physical assessment with vital signs, 2. Neurochecks for any unwitnessed fall or a witnessed fall where resident hits their head: initially then every 15 minutes x 3, then every 30 minutes x 2, hourly x4, every 8 hours x 9. 4. Resident and witness statements regarding the fall, 5. Environmental assessment, 6. Contributing factors to the fall, 7. Medication changes, 8. Mental status changes, and 9. Any new diagnoses. B. update the physician and responsible party of fall and any injuries or change in neurological status. 2. Activate reporting mechanism/tracking of falls within the facility. B. Actions of the interdisciplinary team (IDT) may include: 1. Review of investigation and determination of potential root cause of fall, 2. review of updates to plan of care completed post fall, 3. Additional revisions to the plan of care including any physical adaptation to room, furniture wheelchair, and/or assistive devices, 4. Education of staff as to any care plan revisions, and 6. Verification of timely notification of physician and responsible party to the fall. 40946

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to complete comprehensive bowel/bladder assessments, failed to develop individualized toileting schedule/program, failed to follow the care plan for toileting in order to improve, maintain, or reduce the risk for worsening bowel/bladder function for 4 of 4 residents (R5, R41, R11, R42) reviewed for incontinence. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5 did not have cognitive impairment and did not display signs of delirium (temporary mental state characterized by confusion and anxiety) or rejection of cares. The MDS indicated R5 had diagnoses that included paraplegia, irritable bowel syndrome, diabetes mellitus (DM), and calculus of kidney. The MDS identified R5 required extensive assistance from staff for bed mobility, toilet use, personal hygiene and R5 required total dependence with transfers and dressing. R5's physician orders dated 2/28/20, indicated reposition and check for dryness and change as needed when awake every two hours. R5's care plan dated 6/21/17, indicated bowel and bladder alteration in elimination related to impaired mobility, history of urinary tract infections, urinary incontinence, Crohn's disease, and ileostomy. R5's goal indicated R5 would be clean, dry, and odor free daily with staff assistance. R5's interventions included, keep resident clean and dry, use barrier cream after good peri-care, and apply incontinent products as needed. R5's care plan for activities of daily living (ADL) identified R5 was not ambulatory. The care plan directed staff R5 required daily hygiene/groom and as needed and scheduled repositioning. The care plan also directed staff to check and change R5 every two hours between 5:00 a.m. and 11:00 p.m. with uninterrupted sleep when possible. R5's care plan also identified R5 had a risk for impaired skin integrity related to incontinence and history of pressure ulcer. R5's record lacked evidence of a comprehensive bowel and bladder assessment. R5's last recorded assessment was dated 3/15/19. R5's bladder/incontinence evaluation assessment dated [DATE], indicated R5 was incontinent of bladder due to clothing and incontinence pads being wet with a history of urinary tract infections (UTI's). The assessment did not identify R5's history of incontinence, type of incontinence, frequency, causal factors, or modifiable risk factors. The assessment did not identify/explain how R5's toileting plan/schedule was identified. R5's progress note dated 5/6/22, at 11:09 a.m. registered nurse (RN)-A documented R5 reports not having toileting hygiene and repositioning since 6:00 a.m. During a continuous observation that began on 5/24/22, at 6:50 a.m. and ended at 10:50 a.m. included: -At 6:50 a.m., R5 observed from hallway to be lying in bed by window behind pulled privacy curtain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 6:54 a.m., a staff member wearing royal blue scrubs entered R5's room and heard providing conversation to R5 briefly and then proceeded to remove crash cart from shared room. -At 6:58 a.m., R5 observed lying in bed supine. R5 stated she had not been turned/repositioned or toileted since 5:00 a.m. R5 stated her incontinence brief was soiled with urine. -At 8:30 a.m., R5's head of bed (HOB) elevated to 45 degrees when staff member delivered breakfast tray to room. Staff member did not offer toileting/repositioning. -At 8:45 a.m., R5 stated she has not been turned or repositioned off of her buttocks and remains in wet incontinence brief. -At 8:50 a.m., director of nursing (DON) entered R5's shared room with family of R39. -At 9:36 a.m., licensed practical nurse (LPN)-A administered R5's morning medications. R5 observed on an alternating pressure mattress in bed with HOB at 45 degrees. R5 stated she has not been repositioned off of buttocks or incontinence brief changed since 5:00 a.m. LPN-A did not reposition nor change R5 during the encounter. -At 10:20 a.m., nursing assistant (NA)-B observed entering R5's room with new linens and hospital gown. NA-B completed R5's bed bath and changed linens and re-dressed R5 with a new gown. NA-B changed R5's incontinence brief which was soaked with urine. NA-B stated she had to go get the floor nurse to change R5's treatment dressing on her buttocks as aides were unable to complete that task. -At 10:44 a.m., LPN-A described area as a small reddened, opened area. LPN-A indicated R5 had moisture associated skin damage and the wound had now opened. -At 10:50 a.m., NA-B stated R5 was not on a repositioning or toileting schedule and R5 told staff when she wanted to be changed or turned. NA-B could not articulate R5's toileting schedule according to her care plan. During an observation and interview on 5/25/22, at 10:59 a.m. NA-O observed completing R5's bed bath and applied barrier cream to R5's bottom prior to applying clean incontinence brief. NA-O stated R5 was on an every two hour reposition and toileting schedule from 5:00 a.m. to 11:00 p.m. NA-O stated R5 did not reject cares during the day, but R5 liked to have uninterrupted sleep during the night. When interviewed on 5/26/22, at 9:05 a.m. R5 stated her call light was on from 7:40 a.m. until 9:00 a.m. as she needed to be boosted up in bed and had to lay in the same position until staff responded. R5 stated her legs are sore when this occurs. R5 stated facility staff do not check/change for toileting or reposition her every two hours as they should. R5 stated she lays in wet incontinence brief for extended periods of time and has complained to NA's and nurses; however, nothing gets ever gets done about it. R5 stated staffing has been a concern even prior to the Covid-19 pandemic at facility; however, it has worsened since then. R5 stated facility hires pool agency staff, but they do not seem to care and the care is considerably worse when they are on duty. R5 stated the sore on her buttocks has come and go for nearly one year and it gets red and sore. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 5/27/22, at 12:40 p.m. DON stated expectation for NA's and nurses to follow plan of care as written and to provide turning/repositioning/toileting as ordered. DON stated she expected staff to complete a task if it is charted as completed in medical record and expressed concern if staff are falsely documenting. DON expressed concern of inaccurate bowel and bladder assessments, inadequate bowel and bladder regimens which could lead to potential for urinary tract infections, skin infections and conditions, and skin breakdown. The facility policy titled Incontinence Prevention Program not dated, indicated to provide the appropriate bowel and bladder continence interventions based upon individualized evaluation of residents. R41 R41's admission record identified, an admitted [DATE], with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, unilateral primary osteoarthritis of left knee and anxiety disorder. R41' s admission MDS assessment dated [DATE], indicated that R41 had severely impaired cognitive impairment, physical and verbal behaviors occurred for 4 to 6 days and displayed other behavioral symptoms not directed towards others for 1 to 3 days. R41 did not walk, required extensive assist of 1 with hygiene, extensive assist of 2 with toilet use, dressing, transfers and bed mobility and total dependence of 1 with locomotion and eating. R36 was always incontinent of bladder and bowel. R41's care plan dated 5/16/22, identified R41 at risk for skin integrity condition or pressure ulcers, related to impaired mobility, incontinence of bowel and bladder, and nutritional deficit-malnutrition. Interventions included: frequent repositioning, pressure reduction chair cushion and pressure reduction mattress, avoid friction/shearing while repositioning and keep resident clean and dry use barrier cream after good peri-care, also apply proper incontinent products as indicated. apply dressing to area as needed. Further identified R41 to be dependent on staff for toileting and to offer toileting upon rising, before and after meals, activities and at bedtime. R41's record did not include a comprehensive bowel and bladder assessment that identified how the toileting times were determined. R41's toileting documentation was reviewed; the documentation identified R41 was not assisted/offered toileting in accordance with the care plan. 5/3/22: R41 was toileted twice 5/4/22: R41 was toileted three times 5/5/22: R41 was toileted twice 5/6/22: R41 was toileted three times 5/7/22: R41 was toileted three times 5/8/22: R41 was toileted three times (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/9/22: R41 was toileted three times 5/10/22: R41 was toileted three times 5/11/22: R41 was toileted twice 5/12/22: R41 was toileted three times 5/13/22: R41 was toileted four times 5/14/22: R41 was toileted twice 5/15/22: R41 was toileted twice 5/16/22: R41 was toileted three times 5/17/22:R41 was toileted twice 5/18/22: R41 was toileted twice 5/19/22:R41 was toileted twice 5/20/22: R41 was toileted twice 5/21/22: R41 was toileted three times 5/22/22: R41 was toileted twice 5/23/22 R41 was toileted three times 5/24/22: R41 was toileted three times 5/25/22: R41 was toileted three times 5/26/22: R41 was toileted twice R41 was continuously observed on 5/24/22, from 6:44 a.m. until 10:44 a.m. During observation on 5/24/22, 6:47 a.m. R41 was noted to be well groomed and dressed seated up to the table for breakfast. -At 7:52 a.m. R41 remained seated in his Geri chair in the dining room near the window. -At 8:22 a.m. the DON noted to help assist R41 with eating. -At 8:44 a.m. R41 continued to be seated up to the table in the dining room overlooking the window. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:45 a.m. R41 remained seated in the same spot looking out the window. -At 10:33 a.m. R41 remained in the dining room in his Geri chair, no one has offered to reposition or toilet R41. Toileting and repositioning record indicate he was toileted and repositioned on 5/24/22, at 5:59 a.m. and again at 12:17 p.m. 6 hours without being offered toileting or repositioning. During interview on 5/24/22, at 7:06 a.m. NA-C stated, we are severely short staffed, I don't get to reposition the residents or potty them timely. For example, we have lots of pressure ulcers on this unit within the last few weeks that just happened because we have been running such short staffed. There are four residents that I can think of R4, R41 and R42. It is from not enough staff so we can't reposition them, toilet timely, several ore 2 person transfers, and they are all incontinent. During observation on 5/26/22, at 8:54 a.m. R41 was noted to be seated in his Geri chair in the dining room with his breakfast tray in front of him. During observation and interview on 5/26/22, at 11:08 a.m. NA-E and NA-J assisted R41 to the toilet via ez-stand, RN-B assessed R41's buttocks and noted an open area measuring 1.8 cm x 0.7 cm just to the left of his sacrum. RN-B verified this was a stage 2 pressure ulcer. Skin surrounding the open area was red but blanchable. Area cleansed with NS, foam dressing and bordered gauze applied. RN-B stated she would contact the doctor for dressing order, stated she was not aware he had a pressure ulcer and verified the last mention of his wound to buttocks was shaped redness on 5/9/2,2 and verified his wound had worsened. During interview on 5/26/22, at 11:20 a.m. NA-J verified R41 had not been offered toileting or repositioning since he got up in his chair at 5:39 a.m. R11 R11's admission record identified R11 had diagnoses of muscle weakness, cerebral infarction, dementia with Lewy bodies, and hallucinations. R11's scheduled MDS assessment dated [DATE], indicated that R11 had severely impaired cognition, no walking, required supervision with eating and locomotion, extensive assist of one with locomotion and extensive assist of 2 with bed mobility, transfers, dressing, toilet use and hygiene, used wheelchair for mobility. Always incontinent of bowel and bladder. R11's MD progress note dated 5/16/22, follow up for incontinence associated dermatitis (a type of MASD). R11 complained of pain/discomfort in her groin and intergluteal area, stated it is from her ongoing diarrhea. Nursing reported R11's bottom is raw or sore. Appearance appeared so raw and erythema (red). Current plan, cleanse patient after each incontinence and apply barrier cream, apply hydrocortisone (corticosteroid) cream and clotrimazole (antifungal cream) twice daily. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's care plan prior , dated 9/3/21, indicated at risk for skin integrity condition, or pressure ulcers related to impaired mobility and incontinence, interventions included keep resident dry and clean, use barrier cream, good peri-care, apply proper incontinent products as indicated. R41's CP dated 9/20/21, indicated an alteration in elimination of bowel and bladder related to incontinence, and history of UTI's. Interventions include bowel meds as ordered, call bell within reach, reminders to use, monitor and report signs and symptoms of UTI's, use briefs/pads for incontinence protection. R11's care plan did not identify what type of incontinence R11 had nor a toileting program or schedule. R11's care sheet, TAR and bowel and bladder assessments was asked for and was not provided. R11's toileting toileting frequency documentation identified the number of time R11 was toileted each day. 5/1/22: R11 was toileted twice 5/2/22: R11 was toileted twice 5/3/22: R11 was toileted once 5/4/22: R11 was toileted once 5/5/22: R11 was toileted three times 5/12/22: R11 was toileted twice 5/13/22: R11 was toileted four times 5/14/22: R11 was toileted twice 5/15/22: R11 was toileted twice 5/16/22: R11 was toileted three times 5/17/22: R11 was toileted four times 5/18/22: R11 was toileted once 5/19/22: R11 was toileted twice 5/20/22: R11 was toileted twice 5/21/22: R11 was toileted three times 5/22/22: R11 was toileted twice 5/23/22: R11 was toileted once (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/24/22: R11 was toileted three times 5/25/22: R11 was toileted three times 5/26/22: R11 was toileted three times 5/27/22: R11 was toileted three times 5/28/22: R11 was toileted three times During observation on 5/26/22 10:18 am. RN-B helped assist R11 to her left side while in her bed. RN-B cleaned gluteal cleft with NS. RN-B verified R11 has a stage 2 pressure ulcer on right side of buttock near fold that measures 1.1 cm x 0.6 cm, sacral wound is 2.2 cm x 0.9 cm, and small area of excoriation on left buttock. RN-B stated I will put a gauze dressing on for right now to cover the area and will call MD and get an order for a dressing. According to toileting documentation was last toileted at 5:33 a.m. and last repositioned at 5:32 a.m. R42 R42's admission record identified, an admitted [DATE], with diagnoses that included Alzheimer's disease, dementia, and spinal stenosis. R42's quarterly MDS assessment dated [DATE], indicated that R42 had severely impaired cognition, no walking, extensive assist of one staff with dressing, extensive assist of 2 staff with bed mobility, total dependence of 1 staff with locomotion, hygiene and eating, total dependence of 2 with transfers and toileting, uses wheelchair for mobility. R42 was frequently incontinent of bowel and bladder and no pressure ulcers identified. R42's MD progress note dated 5/6/22, identified new wound measurements from 4/29/22, were 0.7 cm x 0.5 cm x 0.1 cm to intergluteal cleft. Current measurements are 2.1 cm x 1 cm x 1 cm and distal pinpoint 0.3 cm 0.3cm open area. New order for intergluteal Cleft, included Ensure skin is always dry and Ensure patient is repositioned every 2 hours to offload pressure. R42's care plan reviewed and indicated the potential for developing skin alterations due to resistance with bathing and cares from caregivers, often refuses baths and will refuse am and pm cares R42's toileting care plan included check resident before and after meals and prn for incontinent episodes. R42's Care sheet identified toileting should be offered every am and hour of sleep (HS) and before and after meals. R42's care plan did not identify the type of incontinence R42 had and based on the records it could not be ascertained how R42's toileting program was determined, and lacked a comprehensive assessment. R42 had continuous observation on 5/24/22, from 6:47 a.m. until 10:33 a.m. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 5/24/22, at 6:47 a.m. R42 was noted to be seated up to the table in the dining room. -At 7:52 a.m. R42 remained seated in her chair up to the dining room table. -At 8:44 a.m. R42 continued to be seated up to the table in the dining room with her eyes closed. -At 9:45 a.m. R42 remained seated in the same spot at the dining room table with her eyes closed. -At 10:33 a.m. R42 remained seated in the dining room, no one had offered to reposition or toilet R42. During observation on 5/26/22, at 8:06 a.m. R42 was seated in her Broda chair up to the table in the dining room. During observation on 5/26/22, at 8:54 a.m. R42 was seated in her Broda chair, dressed in blue, has a blanket on her lap, with mask on and her eyes closed, she is seated up to the table. During observation and interview on 5/26/22, at 9:33 a.m. R42 was transferred to the toilet with EZ-stand, R42 is noted to not have a dressing on her buttocks. RN-B measures the wound 0.3 cm x 0.6 cm gluteal cleft wound, stage 2. During interview on 5/26/22, 4:01 p.m. DON was notified that there were continuous observations done on 5/24/22, on the third-floor unit for R11, R41, and R42 and they were not moved out of their wheelchairs for almost 4 hours, not offloaded, toileted, or repositioned and all have developed recent pressure ulcers. DON stated her expectation is to offer toileting, repositioned and offloaded per the care plan, especially when they are at risk for pressure ulcers. DON stated they have been short staffed since RN-A abruptly quit. When asked who took over the unit manager for 3rd floor, DON stated, well me and RN-B are trying to. Requested further evidence of a completed bowel and bladder assessments for R11, R41 and R42 and were not received. Facility policy, Incontinence Prevention Program, undated, indicated the purpose is to provide appropriate bowel and bladder continence interventions based upon individual evaluation of residents. 1. Upon admission complete, admission Nursing Evaluation. If any box other than continent is checked begin a urinary continence evaluation. 2. Based on the results of the evaluation of continence, identify of the resident is motivated and cognitively appropriate for a toileting program. 3. Review monthly and document. 4. If no, refer to additional programs: Types of toileting programs: Prompted voiding. Habit training. Routine toileting-a scheduled bladder management program will be designed to toilet an incontinent resident when a voiding pattern cannot be established for a resident that is unable to communicate the need to void. 6. Example schedule in the care plan: A. Toilet the resident every 2 hours, before and after meals, at bedtime and once during the night. 43205

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to provide sufficient nursing staff to provide care and services to assure resident safety and attain or maintain the highest practicable well-being in accordance with resident's comprehensive assessment, individualized care plan, and facility assessment. As a result, systemic system failures were identified in deficient practices in infection control prevention and practices that resulted in an Immediate Jeopardy (IJ), deficient practices in pressure ulcer prevention and care which resulted in harm for 5 of 7 residents (R3, R4, R11, R41, R43), and deficient practices related to bowel and bladder care for (R5, R41, R11, R42). Furthermore inadequate staffing also resulted in supply ordering for resident medication(s), wound supplies, and hand sanitizer. The facility's failures had the potential to effect all current residents that resided in the facility. Findings include: SEE F686 The facility failed to prevent pressure ulcers development or deterioration and promote healing by failing to follow physician ordered treatments, follow the care plan, and ensure comprehensive assessments and monitoring pressure for 7 of 7 residents (R3, R4, R11, R41, R43, R42, R5) reviewed for pressure ulcers. The facility's system failures resulted in actual harm for 5 of 7 residents (R3, R4, R11, R41, R43) when new ulcers developed and/or worsened. The deficient practice has the potential to effect all residents in the facility that are at risk for pressure ulcers. SEE F689 The facility failed to ensure fall program protocols were implemented resulting in system failure. The system failures included, failing to ensure completed comprehensive assessments, identification of causal factors and probable root cause, and development and implementation of interventions that would prevent and/or mitigate the risk of re-current falls and injury. In addition, the facility failed to complete post-fall neurological assessments in accordance with the facility's policy and failed to ensure interdisciplinary involvement process for 6 of 6 residents (R33, R36, R3, R1, R24, R41) reviewed for falls. This had the potential to affect all residents who are at risk for falls residing in the facility. SEE F690 The facility failed to complete comprehensive bowel/bladder assessments, failed to develop individualized toileting schedule/program, failed to follow the care plan for toileting to improve, maintain, or reduce the risk for worsening bowel/bladder function for R5. In addition, failed to provide timely incontinence cares to R41, R42 and R43. SEE F755 The facility failed to provide routine medications and have them available for R5. SEE F880 The facility failed to ensure staff implemented infection control practices to prevent and/or minimize a facility wide outbreak of coronavirus 2019 (COVID 19) for 29 residents who resided at the facility. This systemic system failure resulted in an immediate jeopardy (IJ) and had the potential to affect all 59 residents and staff residing in the facility. Resident observations and interviews: (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During on an observation on 5/24/22, at 7:22 a.m. room [ROOM NUMBER] on the second floor was noted to have a call light on and not answered for thirty-two (32) minutes. During on an observation on 5/24/22, at 7:27 a.m. room [ROOM NUMBER] on the second floor was noted to have a call light on and not answered for sixteen (16) minutes. During on an observation on 5/24/22, at 7:32 a.m. room [ROOM NUMBER] on the second floor was noted to have a call light on and not answered for forty-two (42) minutes. During on an observation on 5/24/22, at 10:20 a.m. room [ROOM NUMBER] on the second floor was noted to have a call light on and not answered for sixteen (16) minutes. During this time period R45 could be heard yelling, can anyone help me please? Please, please please. During an interview on 5/24/22, at 7:58 a.m. R7,an alert and oriented resident, stated staffing was a concern, on a good day there were 4 aides on second floor, recently it has been mediocre with 3 aides. During on an observation on 5/24/22, at 8:37 a.m. room [ROOM NUMBER] on the second floor was noted to have a call light on and not answered for thirty-nine(39) minutes. During an interview on 5/24/22, at 10:13 a.m. R47, an alert and oriented resident, stated facility was short staffed, and it took up to 30 minutes to get the call light answered. R47 indicated he was admitted the beginning of March for a left knee surgery and stated, I fell on [DATE], trying to get to the bathroom and ended up with a subdermal hematoma which has extended my stay. Staff claimed they heard the fall and responded right away. The staff have told me they are short staffed. When I look out into the hallway, I don't see any staff around. During an interview on 5/26/22, at 9:05 a.m. R5, an alert and oriented resident, stated she put her call light on at 7:40 a.m., said she needed help to be boosted up in bed and has had to lay in the same position until staff responded at 9:00 a.m. R5 stated with the long call light wait times it makes her legs sore and further stated the staff do not check and change her or reposition her every 2 hours like they are supposed to. R5 stated she lays in wet depends for extended periods of time, and indicated the short staffing started before COVID hit the building and it has gotten worse since. We do have agency staff, but they don't seem to care, you might just put your light on to get some water, but no one answers it. R5 stated the long call light wait times have not been addressed. Staffing schedule: On 5/25/22, at 10:30 a.m. it was requested for the business office manager (BOM) to print timecards for nursing staff that worked each day. After review of facility documents, Daily Nursing Staffing schedules were not reflective of who worked the floor. Through staff interviews, review of schedule, and the facility assessment the expectation was to have two aides staffed to each unit during the day and evening shifts and to have a nurse or TMA assigned to each unit. For night shift one nurse for second and third floor and two aides on second floor and one aide on 3rd floor. The following days and shifts identified staff shortages: 5/1/22 for day shift, 1 of 4 aides scheduled worked the second floor. For evening shift, 2 of 4 aides scheduled worked the second floor. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	5/2/22: for day shift, 2 of 4 aides scheduled worked the second floor and 1 of 2 aides scheduled worked the third floor. 5/3/22: For night shift, 1 of 2 aides scheduled worked the second floor. 5/5/22: for evening shift, 3 of 4 aides scheduled worked second floor and 1 of 2 aides scheduled worked third floor. 5/6/22: for day shift, 2 of 4 aides scheduled worked the second floor. For evening shift, 3 of 4 aides scheduled worked the second floor, and 1 of 2 aides scheduled worked the third floor. 5/7/22: for day shift, 3of 4 aides scheduled worked the second floor. For evening shift, 3 of 4 aides scheduled, worked the second floor. 5/8/22: for evening shift, 3 of 4 aides scheduled worked the second floor, and 1 of 2 aides scheduled worked the third floor. 5/13/22: for evening shift, 3 of 4 aides scheduled, worked the second floor, and 1 of 2 aides scheduled worked the third floor. 5/14/22: for evening shift, 3 of 4 aides scheduled, worked the second floor, and 1 of 2 aides scheduled worked the second floor. 5/15/22: for day shift, 3 of 4 aides scheduled, worked the second floor. 1 of 2 aides scheduled worked the third floor. For evening shift, 2 of 4 aides scheduled worked the second floor. 5/21/22: for day shift, 3 of 4 aides scheduled worked the second floor. For evening shift, 3 of 4 aides scheduled worked the second floor. 5/22/22: for day shift, 1 of 4 aides scheduled worked the second floor. For evening shift, 3 of 4 aides scheduled worked the second floor. Staff concerns: During an observation and interview on 5/24/22, 6:47 a.m., R3 walked independently down the hallway towards the dining area, with her red four-wheeled walker. While ambulating R3 was hunched over, and her gait was not steady. nursing assistant (NA)-C stated that R3 fell and fractured her hip awhile back, after that she needed more assist. NA-C verified R3 was to be stand by assist with the use of a gait belt when ambulating. NA-C stated, we just don't have enough staff to do that with her, as you can see, she just gets up and goes wherever she wants, we just don't have the staff, and she has fallen several times since her surgery. During interview on 5/24/22, at 7:06 a.m. NA-C stated, we are severely short staffed, I don't get to reposition the residents or potty them timely. For example, R41 came here about 3 weeks ago, by Monday he already had a sore on his bottom that opened, he literally sits in that chair all the time. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During interview on 5/24/22, at 7:48 a.m. NA-B stated on second floor they should always have 4 aides on, we usually only have 1 aide on each side of second floor and then we usually have a (trained medication assistant) TMA on one side and 1 nurse that must run the whole second floor. Most of the time we don't have time to get the showers done and people are not getting turned and repositioned timely. During an interview on 5/24/22, at 9:06 a.m. licensed practical nurse (LPN)-A stated, staffing has really been a challenge, I am the only full-time nurse here, it turns into being mandated at times, usually once a week. During an interview on 5/24/22, at 9:15 a.m. NA-B stated due to staffing shortage we don't get to call lights on time, or turning and repositioning timely, we also only have 1 EZ-stand lift and 1 Hoyer lift for the whole second floor that functions correctly. We also need more staff at mealtimes. 5/24/22, at 9:24 a.m. when asked about staffing, NA-A stated, the residents extra wants are more than we can attend to right now. During an interview on 5/24/22, at 9:49 a.m. LPN-B stated, we are short staffed, we have 1 nurse to 23 residents who need their meds, skin checks after showers and wound care. There should be a nurse to each wing and that does not always happen, a year ago they had 3 nurses assigned to the second floor. The extra nurse did all the wound and dressing changes. Morning med passes are not getting completed until after 11 a.m. We also need more aides in the morning for (activity of daily living) ADL cares such as showers, oral care, and general grooming are not getting done. During interview on 5/24/22, at 9:48 a.m. registered nurse (RN)-B stated, RN-A put in her notice a couple weeks ago, she used to be the third-floor unit manager. RN-B verified that R4's dressing was dated 5/20/22, and further verified it should have been changed yesterday on 5/23/22, per MD orders. After RN-A left we have been super short staffed, I think the measurements for all the wounds up here have kind of fallen off the board. I think the last time R4's wound was measured was 5/3/22, it started out with MASD and now has turned into a stage 2. Wound measurements should be done weekly to determine if the treatment plan is effective. During an interview on 5/24/22, at 12:07 p.m. infection preventionist (IP) stated she started back at the facility on 5/1/22, and further stated the outbreak of COVID started on 5/13/22. On 5/19/22, the DON had called, as there were an additional 8 residents who tested positive and had spread from the second floor to the third floor. We had talked about moving the positive cases to the first floor but were unable to due to staffing shortage. IP stated she had discussed to reach out to the Minnesota department of health (MDH) crisis staffing, but instead we reached out to our corporate office, and we obtained staffing from our sister facilities, we also increased bonuses for this facility to get shifts picked up. IP verified they did not open a COVID unit to cohort positive residents because of insufficient staffing. IP confirmed some residents who were COVID positive did have shared bathrooms with non-covid cases. During an interview on 5/24/22 at 12:32 p.m. the DON stated that they ran out of hand sanitizer because the scheduler was responsible for ordering it and she had quit on 5/17/22, so it never got re-ordered. DON indicated the facility did not have a system in place to ensure supplies were ordered after the staff member left. DON stated she thought there were several bottles of hand sanitizer put out on all of the units. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During observation and interview on 5/26/22, at 11:20 a.m. R3 was seated in her recliner in her room. Registered nurse (RN)-B changed the dressing on R3's coccyx .RN-B did not have any border foam available, she stated when their scheduler quit, she oversaw ordering the supplies and they had been out of border foam dressing for a while now. RN-B used a border gauze dressing instead. RN-B verified all 3 open areas are stage 2 pressure ulcers, and further verified she was not aware of them. During interview on 5/27/22, at 11:08 a.m. director of nursing (DON) indicated the facility has been severely short staffed. DON stated when RN-A (who was the third-floor unit manager) quit on 5/6/22, was when the staffing got bad. DON stated, we have no maintenance staff, no social worker, no unit manager for third floor, no scheduler, and our MDS coordinator is out with COVID, so I am having to fill it all. DON verified they have not hired a replacement for third floor manager and verified no one has been doing the third-floor managers job which includes the RN assessments, falls, wound assessments, and care plan updating. Since RN-A has left, all residents that have had falls on the third floor, their care plans have not been updated with new interventions, and their falls have not been root caused. At 12: 24 p.m. DON admitted that due to the staffing shortage and the loss of the staffing coordinator, she is managing the staffing schedule and does not have time to get into each resident's chart to update the care plan. The IDT discusses fall prevention interventions, they are just not entered into the resident's chart in a timely fashion. At 12:40 p.m. DON stated her expectation would be to have the call lights answered within 10 minutes. DON further stated that the staffing since COVID has been horrible and has been working on staffing since the scheduler up and quit. DON showed surveyor the staffing sheets which indicated there were 36 open shifts for nurses from 5/16/22 to 5/31/22 and 36 open shifts for aides between 5/18/22 to 5/31/22. DON stated, so, we have had the social worker, scheduler, maintenance, and nursing educator all quit. We used to have 3 nurse managers and receptionist, and DON verified they only have 1 nurse manager now. Call light logs were requested and not received. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	A document titled, Facility Assessment Tool, dated 11/2021, indicated, the purpose of this assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. The intent is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services that residents require. Under Resident Profile, the assessment indicated the facility is licensed to provide care for 111 residents: first floor has a maximum capacity of 17, second floor has maximum capacity of 64 and memory care has a maximum capacity of 30 residents. Part 2: Services and care we offer based on our resident's needs. Activities of daily living, mobility and fall/fall with injury prevention, bowel/bladder/toileting programs, skin integrity, medications, management of medical conditions to include early identification of problems/deterioration and identification, containment, and prevention of infections. Section 3.2 indicated the staffing plan will require for licensed nurses (LN) -1 DON full time days, -MDS RN full time days, part time days, -1 ADON/unit managers full time days, and 1 LN for each shift. Day shift short term rehab unit: 1: 17 residents, Day shift days and evening long term care/mixed units 1:22, and LN ratio night shift 1:40, the assessment does not identify the ratio for the memory care unit. For direct care staff: Day shift short term rehab unit: 1: 7 residents, days and evenings, 1:10 might shift, second floor mixed unit 1:10 ratio for days and evenings, 1:19 ratio for night shift. Third floor memory care unit 1:8 ratio for days and evenings and 1:14 ratio for night shift. Other departments heads that are required are: 1 fulltime director of clinical education, 1 full time maintenance staff, 1 full time social services staff, medical supplies that would be available include gloves, gowns, hand sanitizer, gait belts, infection control products and oxygen. Does not identify wound products. Section 3.11 identified the infection control [programs review new state recommendations, participates in quality network ([NAME]) and follows CDC guidelines to ensure the most current practices are in place as it relates to infection control. A line listing for resident infections and a separate line listing for facility staff and others is maintained, reviewed, and analyzed monthly to identify any trends or educational needs or gaps in processes as it relates to infection control. and 1 full time scheduler/central supply specialist. 43205

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43205 Based on interviews and record review, the facility failed to have a system that ensured physician ordered medications were available for administration per physician orders, failed to ensure medication was not documented as administered when medication was not available, and failed to identify missed or late medications as medication errors for 1 of 5 residents (R5). Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 did not have cognitive impairment and identified R5 had diagnoses of irritable bowel syndrome and complex regional pain syndrome. R5's current Order Summary Report with Active Orders as of 5/27/22 included: -Aspercreme lidocaine patch 4% (Lidocaine). Apply to right lower extremity topically one time a day for pain and remove per schedule. Ordered 9/20/21. -Lactaid tablet (Lactase). Give 9000 unit by mouth with meals related to lactose intolerance. Ordered 5/11/20. -Xiidra solution 5% (Lifitegrast). Instill one drop in both eyes two times a day related to dry eye syndrome of bilateral lacrimal glands. Ordered 4/15/22. R5's April and May medication administration records (MARs) were reviewed in conjunction with progress notes. The record identified three medications were not administered in accordance with physician orders because medications were not available at the time of administration. R5's MAR's identified the following: -Aspercreme was not administered on 4/9/22, 5/9/22, and 5/21/22; record indicated medication was not available. R5's progress note dated 5/12/22, at 8:40 p.m. LPN-D documented Aspercreme lidocaine patch 4% was not available to administer. -Lactaid was not administered on 5/11/22 and 5/24/22; record indicated medication was not available. R5's progress note dated 5/23/22, at 5:06 p.m. TMA-B documented Lactaid tablet administered with partial dose given as facility only had two tablets left. R5's progress note dated 5/24/22, at 5:14 p.m. TMA-B documented Lactaid dose was not administered due to facility not having a supply. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Xiidra was documented as not administered on all dates except for 4/15/22, 4/18/22, 4/21/22, 4/25/22, 5/5/22, 5/12/22, 5/16/22, and 5/22/22 when the medication was documented as adminstered; this medication was not available for administration since the order start date of 4/15/22. R5's progress note dated 4/19/22, at 2:03 p.m. licensed practical nurse (LPN)-A documented floor nurse called pharmacy on Xiidra eye drops and per pharmacy it is a payoff $820 for the facility if they are to send them. There is to be a prior authorization for eye drops that they are faxing over to the facility for provider to fill out. Unit manager notified. R5's progress note dated 5/7/22, at 8:06 a.m. trained medication aide (TMA)-B documented Xiidra solution 5% eye drops were not available to administer. R5's progress note dated 5/8/22, at 9:27 a.m. TMA-B documented Xiidra solution 5% eye drops were not available to administer. R5's progress note dated 5/10/22, at 8:13 a.m. LPN-A documented Xiidra solution 5% eye drops were awaiting pre-auth approval. R5's progress note dated 5/20/22, at 10:11 a.m. LPN-E documented Xiidra solution 5% eye drops were not available to administer. R5's progress note dated 5/25/22, at 9:07 a.m. LPN-A documented Xiidra solution 5% eye drops were awaiting pre-auth approval. R5's progress note dated 5/26/22, at 8:34 p.m. registered nurse (RN)-D documented Xiidra solution 5% eye drops were not administered due to medication not being available, pharmacy will not send, and order needs to be discontinued. When interviewed on 5/27/22, at 11:30 p.m. RN-D stated the facility medications are ordered at least once a week because the facility only has two permanent full-time nurses working every day. RN-D stated when part-time or pool agency nurses, or TMA's work then they typically will not reorder medications; they frequently leave administer the last medication and then do not reorder the medication. RN-D stated whoever is assigned to the medication cart oversees reordering medications. RN-D stated staff only need to click on the reorder button on the MAR or fax a sticker from the medication card to the pharmacy. RN-D stated if a medication is unavailable, staff need to ensure they are charting in a progress note why it is unavailable and contact pharmacy immediately. RN-D verified R5's Xiidra solution 5% eye drops were never received by facility and needs a prior authorization. RN-D verified R5's Xiidra solution was incorrectly charted as administered since it was ordered by physician on 4/15/22. RN-D stated she will tell the provider immediately to get the eye drop solution discontinued from medication list or see if there is an alternative option for R5. RN-D verified R5 did not receive Lactaid tablet on dates 5/22/22-5/24/22 as medication was unavailable from their stock medications. RN-D stated the facility scheduler used to be in charge of reordering stock medications; however, she quit her job just prior to them becoming unavailable. RN-D verified Aspercreme lidocaine patch 4% was not available to administer on 5/12/22 and 5/21/22 because the facility ran out. RN-D did not articulate an awareness the medications unavailable at the time of administration was considered a medication error. (continued on next page)

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	245184	A. Building B. Wing	05/27/2022

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Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/27/22, at 12:40 p.m. director of nursing (DON) stated expectation for nurses and TMA's to reorder medications timely by either clicking on the MAR reorder button or remove sticker from medication card and fax to pharmacy. DON expressed concern for resident's not receiving medications when they are due and could affect their multiple comorbidities and diagnoses. DON stated expectation for stock medications to be ordered prior to facility running out and expressed concern since her scheduler quit as she discovered medications were not reordered by an alternative staff member in her absence. DON verified medications should not be charted as administered when a medication is not available as staff should be verifying medications prior to administration. The facility policy titled Medication Administration dated June 2017, indicated to safely and accurately administer physician-ordered medication to each resident. -Promptly record a resident's refusal to take a medication and/or holding a medication, including the reason for refusal and/or holding the medication. A facility policy regarding reordering of medications and stock medications were requested, but never received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review, the facility failed to ensure staff implemented infection control practices to prevent and/or minimize a facility wide outbreak of coronavirus 2019 (COVID 19) for 29 residents who resided at the facility. This systemic system failure resulted in an immediate jeopardy (IJ) and had the potential to affect all 59 residents and staff residing in the facility. The immediate jeopardy began on [DATE], when the facility failed to implement appropriate infection control practices to mitigate or reduce the spread of COVID-19 in the facility. Facility staff did not isolate and/or cohort COVID-19 positive residents appropriately who had shared rooms and bathrooms. Staff did not utilize N95 masks appropriately, did not doff personal protective equipment (PPE) or dispose of PPE after caring for residents who were COVID positive, also did not have a system in place for meal tray removal from Covid positive rooms to prevent cross contamination. In addition, staff were not demonstrating appropriate hand hygiene procedures, there was a lack of available hand sanitizer on all 3 units, and the medical records lacked daily monitoring of residents. The IJ was identified on [DATE], and the director of nursing (DON), director of clinical services DOCS and the infection preventionist (IP), were notified of the IJ at 12:42 p.m. on [DATE]. The immediate jeopardy was removed on [DATE], at 1:35 p.m. when the facility had implemented an acceptable removal plan. However, noncompliance remained at the lower scope and severity level of F, widespread scope, no actual harm with a potential for more than minimal harm that is not immediate jeopardy. Findings include: According to the resident line listing, between [DATE] and [DATE], 30 residents tested positive for COVID-19. The first positive test was identified on [DATE]. According to a staff listing, 11 staff members tested positive during the same period. The facility's resident line listing indicated COVID-19 first started on the second floor with one resident R8, on [DATE]. On [DATE], R9 tested positive. On [DATE], the line listing identified spread to the adjacent 2nd floor hallway with R6 and R10 testing positive. It had also spread on the 3rd floor where two residents tested positive, R11 and R12. On [DATE], 2 more residents tested positive on the second floor, R13 and R14. On [DATE], 6 more residents tested positive on the 2nd floor, these included R16, R17, R18, R19, R20, R21, and R22. On [DATE], 5 residents tested positive on the second floor these included, R23, R24, R25, R26 and R27. On [DATE], 5 additional residents tested positive on the second floor, these included R28, R29, R30, R31 and R32. One tested positive on the third floor R33. On [DATE], R34 from the second floor tested positive. On [DATE], R7 from second floor tested positive and R44 from third floor tested positive. On [DATE], R45 and R46 from second east floor tested positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's infection control program documentation in conjunction with resident records from [DATE] to [DATE]. Infection control records lacked evidence of ongoing prevention strategies such as audits to ensure infection control practices to prevent spread were completed, did not identify an increase for environmental services to clean and disinfect, did not include staff education on COVID-19 prevention strategies, no evidence to suggest intervention or alternative plan for neighboring resident rooms that had shared restrooms, and resident records lacked evidence of consistent monitoring prior to outbreak and lacked increased monitoring for symptoms or other modalities for early detection and testing for containment. Facility's delayed recognition of signs and symptoms of COVID and inappropriate implementation of transmission based precautions (TBP), monitoring for symptoms, implementation of prevention strategies and isolation/quarantine included: R29 shared a room with R23. R21 and R28 resided in the room next door, with a shared bathroom in between the two rooms. According to R29's progress note on [DATE], at 10:20 a.m. identified R29 had symptoms that included productive cough with clear yellowish sputum, sore throat, runny nose, raspy voice, head was stuffy, and he had diminished lung sounds. After R29's symptoms were identified, R29's record lacked consistent assessment and monitoring and lacked evidence TBP and isolation/quarantine were implemented. R23's record indicated he remained in the same room with R29 and lacked consistent monitoring for symptoms and later tested positive on [DATE]. R29 then tested positive on [DATE] (after testing negative on [DATE]) and died later that day ([DATE]). Resident records and the facility's infection control (IC) program did not identify implementation of prevention/containment strategies related to the shared bathroom. R21's record identified he tested positive on [DATE], and became symptomatic with a sore throat and runny nose. R21's progress note dated [DATE] at 10:55 p.m. R21 continued to reside in the same room as R28, record did not identify TBP were implemented, and lacked consistent monitoring for signs and symptoms after testing positive. R28's record identified he tested positive for COVID on [DATE]. R28's progress note dated [DATE] at 9:32 a.m. indicated R23 had symptoms of runny nose and fatigue. R28's record lacked ongoing consistent monitoring for signs and symptoms. During an interview on [DATE] at 8:27 a.m. IP indicated an unawareness of when R29 started having symptoms. IP stated that R29 had a false negative on [DATE] and later tested positive on [DATE]. IP stated the physician did not recommend moving R29 because he was symptomatic and further stated there was no rooms available to move R29 to. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R15 and R26 shared a room. The facility line listing indicated R15 tested positive for COVID on [DATE]. R15's record did not identify R15 was positive for COVID until [DATE] at 2:41 a.m. Progress note dated [DATE] at 2:41 a.m. identified R15 was positive for COVID and R15 had watery diarrhea times four that shift. R15's record lacked consistent monitoring for symptoms prior and after being tested positive. In addition the record did not identify implementation TBP and isolation/quarantine on [DATE]. R15's progress note dated [DATE], progress note dated [DATE] indicated R15 was on and droplet precautions. R15's record did not identify R15 had a room change. The facility line listing was inconsistent with R15's medical record indicating R15 had a room change on [DATE]. R26's record identified inconsistent symptom monitoring. R26's progress notes dated [DATE] indicated R26 had tested positive for COVID, was in a private room, on droplet precautions, and had symptoms of cough, fatigue, and body aches. R26's progress notes and facility line listing indicated R26 remained in the same room. Based on available information between resident progress notes and facility records it could not be determined if or when R15 was moved out of the room. During interview on [DATE], at 12:07 p.m. IP indicated DON cohorted by removing the positive residents with roommates out of the rooms when they tested positive and left the other resident in place. At 12:32 p.m. the DON indicated an awareness R15 was not immediately moved to another room when she tested positive for COVID and indicated an unawareness of when R15 was moved to R9's room. The facility's line listing for staff indicated on [DATE] NA-D was the first to test positive for COVID-19. On [DATE], NA-I tested positive. On [DATE], NA-J tested positive. On [DATE], three staff tested positive, TMA-C, NA-K, and housekeeper (HSK)-B. On [DATE], two staff tested positive, LPN-F and NA-L. On [DATE] NA-M tested positive. On [DATE], NA-N tested positive. On [DATE] RN-F tested positive. Total of 11 staff tested positive from [DATE] to [DATE]. The facility vaccination list identified two unvaccinated staff with religious exemptions (HUC and NA-E) and a listing of staff who had been fit tested for N95's. The list of staff who were fit tested did not identify HUC and NA-E as having been fit tested for N95's. HUC and NA-E were observed working in COVID positive rooms during the survey. During observation on [DATE] at 6:38 a.m. on the second east floor, two of four hand sanitizer stations did not work or were empty. During observation on [DATE], at 6:58 a.m. on the third east floor, two of four hand sanitizer pump that hung on wall were empty. Nursing assistant (NA)-C verified they were both empty and was unsure who oversaw keeping the pumps filled. No individual bottles of sanitizer were observed anywhere on the unit. The nurse's station had open pop cans, used masks laying on the desk, and counters had dried wet marks on them. During observation and interview on [DATE], at 8:15 a.m. R36 was noted to be fully dressed lying in bed; R36's door was open. NA-C stated to surveyor be careful with R36, his roommate R33 just tested positive for COVID yesterday and we moved R33 to a private room down the hall. NA-C stated R36 needs to be on precautions for COVID because he was exposed. NA-C stated R36's room did not have precaution signage nor a PPE cart outside the room yet. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During observation on [DATE], at 8:30 a.m., HUC delivered 2nd floor breakfast trays to COVID positive and COVID negative residents. Although she appropriately donned/doffed gown, gloves, and performed hand hygiene she wore an N95 mask that she was not fit tested for and did not change between tray deliveries. During an observation on [DATE], at 8:48 a.m. HSK-A was observed mopping floor on the third-floor hallway, HSK-A then entered R36's room with the mop; HSK-A entered with gloves, mask, and goggles on. HSK-A finished cleaning R36's room and exited without doffing any of the PPE and without performing hand hygiene HSK-A then entered R37's room who was not COVID positive. HSK-A stated an unawareness that R36 had been exposed to COVID. HSK-A stated if he had known he would sanitize those rooms last, and wear a gown and a face shield. During observation on [DATE], at 9:52 a.m., NA-A entered R22's room who was COVID positive with surgical mask on to gather food tray. Upon exiting R22's room, NA did not change face mask. NA-A walked down hallway and placed R22's food tray on a communal food cart that was not covered. NA-A did not perform hand hygiene NA-A then entered R32's room who was not COVID positive. During observation on [DATE], at 10:11 a.m. environmental Service Director (ESD) was delivered hand sanitizer refills to the second east hallway. ESD did not identify the batteries were dead in the hand sanitizer pump; the pump continued to not function. During observation on [DATE], at 10:12 a.m. NA-B had a surgical mask on. NA-B put on a gown entered R23's room who was COVID positive. Prior to leaving the room NA-B removed her gown, and without gloves on picked up R23's tray and water mug, walked out of the room and placed the the items on the dirty linen cart in the hallway. NA-B then picked up the tray, placed the tray in the communal tray cart, picked up the mug, picked up a water pitcher, went to the ice cooler by the nurse's station, filled it with ice and water, placed the mug on the water fountain to secure the lid. NA-B then obtained gloves from room [ROOM NUMBER], put the gloves on, and handed the water pitcher to R23 in the doorway of their room. NA-B then removed the gloves and threw them away in the waste receptacle attached to the treatment cart. At no time did NA-B disinfect the items she removed from R23's room nor perform hand hygiene. After giving R23 water pitcher NA-B then briefly talked to the nurse standing near by, then touched the handle of clean linen room, obtained clean hospital gowns and shut the door. NA-B then walked to the west linen closet, touched the handle, obtained another gown, placed it on the hallway outside room [ROOM NUMBER]. NA-B then sanitized her hands and entered the room. NA-B never changed the surgical mask throughout the observation. During observation on [DATE], at 8:31 a.m. NA-B came out of R23's (covid positive) room, removed surgical mask, placed the plate cover on the handrail, then picked it back up and placed it on the dirty linen cart. NA-B did not perform hand hygiene before putting a new mask on outside of R30's room who was COVID positive. After putting the mask on NA-B donned PPE outside of R30's room, entered the room and picked up the plate cover, NA-B removed PPE, performed hand hygiene, then took the plate cover to the steam cart and placed it on top of cart to go down to kitchen. During observation on [DATE], at 8:41 a.m. The PPE cart outside of R21 and R28's (COVID positive) room was empty. The PPE cart outside of R23's (COVID positive) was also empty. The cart outside of R24's (COVID positive) room cart was not stocked with N95's and the PPE cart outside of R34's (COVID positive) room was not stocked with surgical masks or N95's. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During observation on [DATE], at 8:49 a.m. NA-D was observed in R35's room who was COVID positive, NA-D had full PPE that included a surgical mask. NA-D doffed inside R35's room however did not remove the surgical mask. NA-D sanitized hands, picked up R35's food tray and carried it down the hallway, and placed the tray on the communal food cart. NA-D was not observed to perform hand hygiene after putting the tray on the cart. During an observation on [DATE], at 8:56 a.m. An uncovered waste canister was outside R17's room, with used PPE. Trained medication assistant (TMA)-A was observed in R17's room who was COVID positive wearing an N95 mask, gloves, and gown on. TMA-A exited R17's room with the same N95 on, with gloves on, and without performing hand hygiene. TMA-A then walked to the medication cart and threw the gloves into the waste canister attached to the medication cart, sanitized her hands, doffed the N95 and put in waste basket, TMA-A did not perform hand hygiene after touching the N95 and replacing with surgical mask. TMA-A indicated education on infection control had not been provided since the COVID outbreak. On [DATE], at 9:17 a.m.NA-E was observed to be wearing a surgical mask while working the floor and was not fit-tested . During observation on [DATE], at 5:04 p.m. registered nurse (RN)-D was observed leaving R5's (covid positive) room with a surgical mask and not an N95, RN-D did not doff and change the surgical mask. During observation on [DATE], at 10:15 a.m. NA-D was observed in R10's room (COVID positive), was not wearing eye protection while in the resident's room. During observation on [DATE] at 10:20 a.m. RN-D observed family member (FM)-A walk into R34's (COVID) positive) room to visit wearing only a surgical mask, no other PPE worn. FM-A was observed to go in and out of R34's room twice. RN-D instructed FM-A to shut R34's room when visiting but did not ask FM-A to wear full PPE. During observation on [DATE], at 10:33 am breakfast trays from second floor east unit COVID positive rooms were still being delivered to communal food cart, to go back to kitchen. During an interview on [DATE], at 7:06 am, NA-C stated, I think more than half our staff in the whole building had covid. R29 passed away last night after he tested positive for covid yesterday, his roommate R23 was positive, I don't think they ever took R29 out of his room when R23 tested positive, and now R29 is dead. NA-C indicated an unawareness R29 had developed symptoms prior to testing positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE], at 12:07 p.m. IP stated she started back at the facility on [DATE], and further stated the outbreak of COVID started on [DATE]. R8 was the first one who tested positive and was tested because she started having symptoms that day. R8 was someone who hardly ever left her room, we figured she may have gotten COVID when she left the facility for an appointment on [DATE]. When R8 tested positive we started facility wide testing. Our next positive case was NA-D, he tested positive on [DATE], after having symptoms that day. IP verified that NA-D had worked the whole weekend from [DATE], to [DATE], and had worked directly with R8 and worked all of the units. As more residents tested positive, we would remove the positive resident from the room to a private room. On [DATE], the DON had called, as there were an additional 8 residents who tested positive and had spread from the second floor to the third floor. We had talked about moving the positive cases to the first floor but were unable to due to staffing shortage. IP stated she had discussed to reach out to the Minnesota department of health (MDH) crisis staffing, but instead we reached out to our corporate office, and we obtained staffing from our sister facilities, we also increased bonuses for this facility in order to get shifts picked up. IP verified they did not open a COVID unit to cohort positive residents because of insufficient staffing. IP confirmed some residents who were COVID positive did have shared bathrooms with non-covid cases. During an interview on [DATE] at 12:32 pm DON stated that they ran out of hand sanitizer because the scheduler was responsible for ordering it and she had quit on [DATE], so it never got ordered. DON indicated the facility did not have a system in place to ensure supplies were ordered after the staff member left. DON stated she thought there were several bottles of hand sanitizer put out on all of the units. DON indicated the facility was still allowing visitation and visitors were instructed to wear full PPE when visiting COVID positive residents, then doff, and head straight out. During interview on [DATE], at 8:43 a.m. IP brought in a list of staff that were N95 fit tested , the list did not include the two unvaccinated staff who had religious exemptions (HUC and NA-E). The list had a total of 11 staff that had been fit tested . IP reviewed the list and confirmed the list was a complete staff list that the facility gave to her and verified the two unvaccinated staff were not fit tested . IP stated she was currently setting the HUC up today for medical evaluation. IP verified NA-E had been working the floor without being fit testing for N95 and indicated an unawareness HUC had been working on the floor. During interview on [DATE], at 8:45 a.m. licensed practical nurse (LPN)-B stated they have not been fit tested for N95's. LPN-B stated there had not been any education or audits completed in regard to COVID-19 since the outbreak. When asked about donning and doffing PPE in COVID positive rooms, LPN-B stated the facility did not provide N95 masks everyday, so they were not doffed after each resident encounter During interview on [DATE], at 9:02 a.m. NA-D stated he had worked here for 2 years, stated he knew nothing about fit testing N95 masks. During interview on [DATE], at 9:15 a.m. LPN-A stated she was not fit-tested and verified there was no formal education completed in regard to COVID outbreak. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on [DATE], at 11:02 a.m. RN-D stated no one told her that visitors needed full PPE when visiting COVID positive residents. Also stated they were not educated on food trays from positive rooms going on the communal cart. They educated about IC PPE, donning/doffing, leaving everything in the room, hand hygiene, and putting clean mask on as soon as you come out. On [DATE], at 12:13 p.m. The DON and nurse consulting team were notified of inappropriate ICP practices being followed by staff; IP stated she re-educated all staff the evening prior. IP stated she would re-educate staff on the spot. IP was observed to go and reeducate all staff in the building on the spot in regard to the above concerns. During observations and interviews on [DATE], at 12:13 p.m. across the units during the lunch hour, no PPE breeches were noted, and facility opted to use paper dining ware for COVID positive residents to avoid cross contamination. The IJ that was identified on [DATE], at 12:42 p.m. and was removed on [DATE], at 1:35 p.m. when it could be verified the facility had developed and implemented an acceptable removal plan including: Staff education was provided regarding appropriate use of PPE and hand hygiene with COVID positive residents and visitors, appropriate techniques for discarding contaminated supplies. These measures were verified by staff observation, interview, and review of facility documentation. 43205