| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245264 | A. Building<br>B. Wing | 07/18/2024 |

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| Apple Valley Village Health Care Center | 14650 Garrett Avenue<br>Apple Valley, MN 55124 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034<br><br>Based on interview and document review, the facility failed to ensure a resident/ resident representative's voiced grievances, were tracked through the facility-established grievance process, and the resident representative was updated on the resolution of the grievance for 1 of 1 residents (R55) who had reported missing clothing items and care concerns.<br><br>Findings include:<br><br>MECHANICAL LIFT<br><br>R55's quarterly Minimum Data Set (MDS) dated [DATE], indicated R55 had moderate cognitive impairment and was dependent on staff for hygiene, bathing, and transferring.<br><br>R55's care plan dated 3/3/23, indicated that R55 required the total assistance of two staff members using a full body lift for transfers.<br><br>An email correspondence from resident representative (RR)-B and registered nurse (RN)-D, the unit nurse manager, dated 6/21/24 at 7:43 p.m., indicated RR-B had witnessed an unknown staff member use a mechanical lift to transfer R55 to bed independently.<br><br>Another email correspondence from resident representative (RR)-B and RN-D dated 6/24/24 at 10:09 p.m., indicated RR-B had witnessed an unknown staff member use a mechanical lift to transfer R55 to bed by independently.<br><br>A Performance Improvement Form dated 7/2/24 at 3:10 p.m., indicated a meeting had occurred between RN-D and nursing assistant (NA)-F and confirmed NA-F had used a full-body mechanical lift to transfer R55 by themselves. The form indicated what action management had taken and mechanical lift education that had been provided.<br><br>A Performance Improvement Form dated 7/5/24 at 2:31 p.m., indicated a meeting had occurred between RN-D and NA-G and confirmed NA-G had used a full-body mechanical lift to transfer R55 by themselves. The form indicated what action management had taken and mechanical lift education had been provided.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of grievances from 1/16/24 to 7/16/24 was completed and identified nine grievances for the six-month period. The facility lacked a grievance form for R55.<br><br>R55's record was reviewed and lacked evidence that R55's concerns were addressed through the facility grievance process to determine what, if any, other actions were needed to ensure all staff were aware of the care plan and, if needed, re-educated to ensure appropriate, safe transfers for R55.<br><br>During an interview on 7/16/24 at 1:15 p.m., resident representatives (RR)-A and RR-B stated they visited R55 daily and had a camera in R55's room for observing when R55 needed assistance. RR-A and RR-B stated they had communicated multiple concerns with the facility they felt had not been resolved. RR-A stated she had emailed and discussed in person a concern regarding two different staff members, on two separate occasions, using the mechanical lift by themselves to transfer R55 when they thought two staff members were needed. RR-A stated she did not feel R55 was safe knowing this had occurred and not knowing what, if anything, the facility had done to correct this issue that could have caused harm to R55. RR-A stated they now felt like they had to continuously watch the camera to ensure RR-A was receiving safe care and they should not have to do this.<br><br>During an interview on 7/17/24 at 8:50 a.m., RN-D, the unit nurse manager, stated she had a conversation with R55's representatives and had realized that she was not receiving emails from them due to an IT issue. RN-D stated she became aware of the representative concern regarding the one-person mechanical lift use a couple of weeks ago. RN-D stated education and final warnings were given to the two staff members involved on their next shift. RN-D stated she had informed the family that would look into this concern and complete education with the two staff members involved but did not file a formal grievance and had not followed up with R55's representatives after education and the investigation was completed. RN-D stated she talked with R55's family often and if they had continued concerns regarding this issue, they could have asked for an update.<br><br>During an interview on 7/18/24 at 10:04 a.m., the director of social services (DSS), the grievance official, stated floor staff had access to grievances forms they could fill out and then bring to her so she could track the issue and make sure the concern was addressed by all of the appropriate parties. The DSS stated she babysat the concern as it goes through the grievance process to ensure it reaches resolution and then ensures that resolution is brought to the resident/ resident representative. The DSS stated she expected staff to complete a grievance form when the issue had occurred on more than one occasion or could not be fixed instantly. The DSS stated there was value in having documentation so the issues could be tracked.<br><br>During an interview on 7/18/24 at 11:44 a.m., the director of nursing (DON) stated the DSS was in charge of grievances and grievance forms could be found throughout the facility form for residents and families to complete when they had a concern. The DON stated if a concern was brought to a staff member, it was up to that staff member's discretion to decide if an official grievance needed to be completed. The DON stated the facility did not have official criteria to determine when filing a grievance was necessary. The DON stated they had not filed an official grievance regarding staff using a mechanical lift to assist R55 because the issue was followed up on so quickly and taken care of right away. The DON stated that RN-D had informed R55's representative that education would be provided when the concern was brought forward. The DON stated because education had been given to staff immediately she did not think it was necessary to follow up with the representatives after the investigation and education were completed.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | MISSING ITEMS<br><br>On 7/17/24 at 3:02 p.m., a request was made for any reports of missing items for R55 in the last six months. A reply was received on 7/17/24 at 3:21 p.m., from the Director of Social Services (DSS) indicating no missing items were reported for R55 in 2024.<br><br>During an interview on 7/16/24 at 1:15 p.m., RR-A stated they had noticed multiple of R55's clothing items go missing in the last few months and they had notified facility staff however had not heard anything about it since then.<br><br>During an interview on 7/17/24 at 2:13 p.m., nursing assistant (NA)-A stated she had noticed a few of R55's outfits go missing over the last few months and she had looked for the outfits however had never found them. NA-A stated she did not fill out a missing laundry form and was unsure if anyone else had.<br><br>During an interview on 7/18/24 at 10:29 a.m., RN-D, the nurse manager of the unit, stated she was not aware of any of R55's personal items missing however if it had happened, she would have expected a report to have been sent to the DSS.<br><br>During an interview on 7/18/24 at 12:19 p.m., the DSS stated the facility used a separate system for tracking lost items than for following grievances. The DSS stated she was in charge of tracking lost items and had a form she expected any staff member to fill out if they noticed or were notified of a resident missing a personal item. The DSS stated when she was notified of a missing item, a further investigation was completed including a facility-wide email and monthly summary that she followed. The DSS stated that if an item was not recovered, they were pretty flexible about reimbursing residents for items that had gone missing. The DSS confirmed that she had reviewed her records and had not found evidence that a form had been completed for R55.<br><br>The facility Grievance policy dated 10/20/23, indicated grievances could be filed orally or in writing, and all grievances would be responded to within seven days. The policy indicated the staff person receiving the concern would initiate the grievance form and it would then be routed to the grievance official. The grievance official would ensure any necessary investigations were completed as well as corresponding documentation. The policy indicated that once the grievance investigation was completed, the form as well as the written grievance decision would be sent to the facility administrator for review. The documentation would also be sent to the facility's quality assurance person for review and tracking using a grievance tracking log. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925<br><br>Based on observation, interview, and document review, the facility failed to ensure routine grooming and personal hygiene care (i.e., nail care) was provided for 1 of 3 residents (R60) reviewed for activities of daily living (ADLs) and who was dependent on staff for such care.<br><br>Findings include:<br><br>R60's admission Minimum Data Set (MDS), dated [DATE], identified R60 had moderate cognitive impairment, demonstrated no delusional thinking, and did not have diabetes mellitus. Further, the MDS identified R60 required supervision and/or touching assistance to complete personal hygiene cares.<br><br>On 7/15/24 at 2:21 p.m., R60 was observed in his wheelchair while in his room. R60 had a visible, slight finger contracture present on his left hand but had multiple long fingernails present on both hands with the edge of the nail being several millimeters (mm) long on some of them and some nails having a dark-colored debris present under the edge. R60 was interviewed and stated he was getting help with bathing once a week but needed help with his fingernail clipping adding, These [nails] are too long. R60 stated he thought he had been asked about clipping them prior but was not sure when or why they hadn't been clipped. R60 reiterated he wanted his nails clipped adding, Yea.<br><br>R60's care plan, dated 6/21/24, identified R60 had multiple medical conditions including Parkinson's Disease and chronic kidney disease (CKD). The care plan outlined R60 required assistance to complete his ADLs along with various interventions including, GROOMING: Staff to provide assist with grooming. The care plan lacked any intervention or direction on nail care and/or preferred nail length, if applicable.<br><br>R60's most recent Visual Body Inspection(s), dated 7/3/24 and 7/10/24, were reviewed. These identified R60 had no new skin impairments (i.e., bruises, pressure sores); however, lacked detail or evidence R60's nails had been reviewed with the completed skin check.<br><br>R60's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 7/2024, identified R60's provided and recorded medications along with his completed treatments. These both lacked evidence of any nail care had been completed or offered during the month period thus far.<br><br>On 7/16/24 at 1:32 p.m., nursing assistant (NA)-A was interviewed. NA-A explained they had worked with R60 a few times since he admitted to the care center and stated the NA(s) were responsible for nail care if the resident was not diabetic. NA-A stated nail care should be completed weekly adding, We do with the baths. NA-A stated R60 was typically accepting of care and, at request of the surveyor, observed R60's fingernails. NA-A verified their length and condition and expressed they were unsure when they had been last clipped or trimmed. NA-A stated nail care, either when offered or completed, was not routinely documented in their charting and expressed, Maybe the nurse [does]. NA-A verified R60 would need staff help to clip his fingernails.<br><br>R60's entire medical record including progress notes was reviewed and lacked evidence what, if any, nail care had been offered or completed for R60 within the past several weeks.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | When interviewed on 7/16/24 at 1:40 p.m., registered nurse (RN)-C explained nail care should be completed with the weekly bathing schedules and expected the care completed adding, They should be done. RN-C stated the nurses only recorded nail care on the MAR/TAR, if applicable, to their knowledge and verified the NA(s) were able to clip or trim fingernails for non-diabetic residents.<br><br>On 7/16/24 at 1:51 p.m., registered nurse unit managers (RN)-A and RN-B were interviewed. RN-A explained nail care should be done with the scheduled bathing but could also be done whenever needed. RN-A stated they expected fingernails and toenails to be checked and, if needed, attended to or clipped. RN-A stated nail care was not necessarily documented unless it was offered and refused adding nail care was more a standard of care with a bath. RN-A verified R60 likely needed help to clip his fingernails and stated it should be completed for proper hygiene. RN-A stated they would review the medical record and provide documentation of nail care if located.<br><br>No further medical record information was received.<br><br>A provided Nursing Assist Standard Cares policy, dated 3/2024, identified nursing staff would provide quality care to those served and listed standard cares which would be provided unless indicated on the care plan. The list of cares or services included, 8. Nail care weekly and PRN [as needed]. Nails should be short and clean. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925<br><br>Based on observation, interview, and document review, the facility failed to ensure a developed skin condition was comprehensively assessed and, if needed, acted upon or monitored to ensure healing for 1 of 1 resident (R141) reviewed who had large areas of dry, flaking skin present on their leg.<br><br>Findings include:<br><br>R141's admission Minimum Data Set (MDS), dated [DATE], identified R141 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R141 had several medical conditions including anemia; however, R141 had no current wounds, skin ulcers, or other skin-related problems.<br><br>R141's Nursing Admission, dated 6/23/24, identified R141 admitted from the hospital on the same date and outlined multiple body systems to review along with areas to record what, if any, conditions or issues were identified. The completed evaluation identified no edema was present on R141's lower extremities, however, there was no recorded spaces or areas to record what, if any, skin conditions were present.<br><br>R141's care plan, dated 6/24/24, identified R141 was at risk for skin integrity alteration due to multiple medical conditions and decreased mobility. The care plan listed a goal which read, Skin will remain intact through 90 days, along with interventions including encouraging him to elevate his heels in bed, pressure-relieving cushions, a licensed staff visual body inspection weekly and, [Nursing assistant] to observe skin daily during cares and notify nurse promptly of any areas of concern.<br><br>On 7/15/24 at 7:02 p.m., R141 was observed lying in bed while in his room. R141 was interviewed and explained he admitted to the care center after having a fall at his home where he sustained a hematoma (a collection of blood trapped outside the vessel under the skin) on his right leg. R141 pulled up his right pant leg which showed a large, black-colored area on the swollen lateral right thigh; however, nearly the entire surface of the leg extending down to the foot had visibly dry, flaking skin present as well with some skin flaking falling off as the pant leg was re-adjusted. R141 stated the scaling just falls off lately and he was unsure what, if any, treatment or monitoring was being done adding there was no consistent cream or ointment being applied to his recall. R141 stated the skin was somewhat itchy and sore but added it's not near as bad as it was [prior]. R141 stated he believed the staff was aware of the condition.<br><br>When interviewed on 7/17/24 at 9:31 a.m., nursing assistant (NA)-A stated they had worked with R141 prior and described him as very much independent with most cares. NA-A stated they had observed R141's right leg and expressed it had a black area on it along with dry skin. NA-A stated they don't know exactly how long the dry skin had been present but added, I think when he came, think so. NA-A verified the dry skin had been present for at least a week to their recall and, as a result, the NA(s) were trying to lotion it when able or if R141 asked for it. NA-A stated the nurses had not directed anything specific for it to their knowledge (i.e., lotion twice a shift) and stated the area appeared kind of the same since they had first noticed it prior. NA-A stated the nurses were aware of it to their knowledge adding, I think so.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R141's most recent Comprehensive Skin Risk with Braden, dated 7/14/24, identified R141 needed assistance with activities of daily living (ADLs), had cardiovascular disease and chronic kidney disease (CKD). An attached Braden Scale (used to screen for pressure ulcer risk) identified a score of 16.0 which was labeled, At Risk. This evaluation identified R141 had bruising present which was not required to be tracked in Wound Management, however, lacked any evidence R141 had dry skin present or what, if any, treatment or monitoring of it was being done despite floor staff knowledge of it.<br><br>R141's completed Visual Body Inspection(s), dated 6/23/24 to 7/13/24, identified a total of four evaluations were completed. The last completed, on 7/13/24, identified R141 had no skin issues on his heels along with no new skin issues elsewhere with dictation present, No new skin concerns. Neither of the four completed inspections had any dictation or indication of the developed dry skin condition. In addition, R141's Wound Management tracking, located in the electronic medical record (EMR), lacked any specific tracking or monitoring of the developed skin condition.<br><br>R141's medical record was reviewed and lacked evidence the developed skin condition had been comprehensively assessed to determine what, if any, interventions were needed to ensure healing. The record lacked evidence of any current treatments. Further, the record lacked evidence the condition had any ongoing, routine monitoring to ensure healing and prevent complication or worsening.<br><br>When interviewed on 7/17/24 at 9:38 a.m., registered nurse (RN)-C stated they had just noticed that morning R141 had dry skin on his right leg so, as a result, they made a note to contact the medical provider about it and get treatment started. RN-C stated they had noticed R141's right leg yesterday, too, however, didn't feel it was as much [as bad] as now adding it looked so dry. RN-C verified today (7/17/24) was the first time it had been reported to them from the overnight shift. RN-C explained new skin issues or conditions, such as dry skin, should be reported and assessed to determine any treatments needed adding such would be recorded in the progress notes. RN-C verified R141 had no current treatments in place for the dry skin and added, We should get some orders.<br><br>On 7/17/24 at 1:59 a.m., registered nurse unit managers (RN)-A and RN-B were interviewed. RN-A verified they had reviewed R141's medical record and explained when a skin condition was identified, then the nurse should evaluate it and update the provider, if needed. RN-A and RN-B expressed if a NA finds a skin issue, they expected the nurses to be notified. RN-A stated the wound nurse had just today looked at R141's leg who applied lotion to what was described as a lot of that dry, flaky skin. RN-A stated the wound nurse had not been involved with the developed dry skin prior but had just noticed it today when in there observing his skin for other reasons. RN-A explained any evaluation or assessment of a skin condition would likely be under the assessments within the EMR, however, it lacked anything completed. RN-A stated any developed skin condition not improving after a period of treatment should also be re-evaluated and the medical provider updated. RN-A and RN-B both expressed neither of them had been updated on R141's dry skin prior to that day and explained floor staff had various means to update them, if needed, such as e-mail or verbal report. RN-A stated had someone updated them, then it would have been reviewed and evaluated by themselves or the wound nurse sooner. RN-A stated it was important to ensure skin conditions, including dry skin, were evaluated and acted upon timely as we don't want any further issues [i.e., infection, complication].<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A provided Skin Integrity policy, dated 3/2024, identified skin care, the assessment of risk and treatment plans would be based on resident' goals. The policy outlined, Cassia facilities will use the Wound Management area of the MatrixCare [EMR] to document skin integrity issues. A procedure was listed which included, NAR will inspect skin daily with cares. Any skin alterations will be reported immediately to licensed nurse, and, Nurse will communicate new skin alterations to the interdisciplinary team, MD/NP/PA, and the resident representative. Further, the policy added, Nurse will follow documentation guidelines below for any new skin alterations, which included implement appropriate treatment, completion of a new skin risk assessment if pressure or mixed etiology, and update the care plan. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034<br><br>Based on observation, interview, and document review, the facility failed to consistently implement a restorative nursing program (RNP) to prevent a possible decrease in mobility for 1 of 1 residents (R52) reviewed for range of motion.<br><br>Findings include:<br><br>R52's quarterly Minimum Data Set (MDS) dated [DATE], indicated R52 had intact cognition with no rejection of care behaviors during the look-back period (LBP). The MDS indicated R52 required maximal assistance for transferring, moderate assistance with bed mobility, and walking was not attempted. The MDS indicated R52 received occupational therapy and physical therapy during the LBP but was not on an RNP.<br><br>R52's care plan dated 7/3/24, indicated R52 was on a RNP and was to receive stand-by assistance (SBA) and verbal cues while ambulating 500 feet daily.<br><br>R52's orders were reviewed and did not reference an RNP.<br><br>R52's Point of Care History report dated 7/4/24 through 7/16/24, indicated R52 had completed his RNP twice during the period, 11 times the field was left unanswered, and on one occurrence it was documented as deferred due to condition. The report did not identify when or if R52 had refused his walking program.<br><br>R52's medical record was reviewed and lacked indication that R52 had been offered or refused his RNP from 7/4/24 through 7/16/24.<br><br>R52's physical therapy Discharge Summary dated 6/25/24, indicated on discharge from physical therapy, R52 was ambulating up to 500 feet with SBA and verbal cues. The summary indicated that R52 continued to require assistance with ambulation and was on an RNP.<br><br>During an interview on 7/15/24 at 3:28 p.m., R52 stated when he was discharged from physical therapy in late June 2024, he was supposed to be on a walking program. R52 stated since he had been discharged from physical therapy, he did not recall anyone offering the walking program to him.<br><br>During an interview on 7/17/24 at 10:05 a.m., physical therapist (PT)-A stated after reviewing R52's medical record, R52 had an RNP that included ambulating 500 feet with SBA daily. PT-A stated it was important this program was completed consistently, so R52 maintained his ability to walk as was established in physical therapy.<br><br>During an interview on 7/17/24 at 10:14 a.m., nursing assistant (NA)-D stated R52 had never refused assistance from him. NA-D stated he was unsure if R52 was on an RNP however thought he might have been receiving assistance with range of motion.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 7/17/24 at 12:00 p.m., NA-D stated after talking with R52 he thought aides had not been remembering to offer R52 his RNP and was observed instructing R52 to ask staff when he wanted to complete the walking program.<br><br>During an interview on 7/18/24 at 10:15 a.m., registered nurse (RN)-D, the nurse manager for the unit, stated the RNP would populate as a task the aides had to complete for their documentation so the aides should have been aware of the RNP. The Point of Care History was reviewed with RN-D who confirmed the documentation indicated R52 had not received his RNP consistently and did not include an indication of refusals in the documentation.<br><br>During an interview on 7/18/24 at 11:38 a.m., the director of nursing (DON) stated the instructions for the RNP could be found in the resident's care plan, and documentation of completion was found in the Point of Care History. The DON stated if the restorative nursing program was refused, this would also be documented in the Point of Care History.<br><br>The facility Restorative Nursing/Functional Maintenance Program Review policy dated 3/28/24, indicated the RNP would have been entered into the care plan and scheduled in the point of care documentation for aides to complete. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>47495<br><br>Based on observation, interview and document review, the facility failed to ensure an appropriate medical justification was documented for an indwelling catheter and failed to attempt a trial discontinuation without medical justification for continued use for 1 of 1 resident (R35) reviewed for catheter use.<br><br>Findings include:<br><br>R35's quarterly Minimum Data Set (MDS) dated , 6/18/24, indicated R35 was cognitively intact and had an indwelling catheter.<br><br>R35's Resident Face Sheet, printed 7/17/24, indicated R35 had multiple medical diagnoses including personal history of urinary (tract) infections and other specified disorder of bladder-bladder spasms.<br><br>R35's physician ordered, dated 7/16/24, instructed staff to change foley catheter every two weeks and PRN [as needed] for leaking or decreased urine output with signs of bladder distension. 18 FR [French] 10CC [milliliters]. The order instructed the staff to change the foley catheter once a day on the 2nd and 17th of the month.<br><br>R35's care plan, revised 7/2/24, indicated R35 required assistance with toileting due to impaired balance/gait and incontinence with a foley catheter in place for urinary output. Interventions included leaving approximately 200 milliliters (ML) of urine in the foley catheter bag when emptying per resident preference.<br><br>R35's Electronic Medical Record (EMR) lacked medical necessity or justification for the use of a urinary catheter.<br><br>R35's EMR indicated R35 had two urinary tract infection (UTIs) in the past 6 months.<br><br>A hospitalization note, dated 1/8/24, indicated R35 was hospitalized due to nausea, vomiting, diarrhea and pain with urination in her urethra with a diagnosis of UTI due to Foley catheter and a history of Extended-spectrum beta-lactamases (ESBL) UTI. The hospitalization further indicated R35 had a previous hospitalization in October 2023 with similar presentation with a UTI due to Foley catheter.<br><br>A M Health Fairview Geriatrics provider note, dated 2/16/24, indicated R35 was visited due to concerns regarding increased lethargy and paranoia. The note indicated a urine analysis and culture was collected and came back grossly abnormal in the setting of indwelling Foley catheter. The note further indicated R35's indwelling foley catheter was placed years ago due to chronic dysuria [painful urination] and that R35 historically has not struggled with urine retention. The note further indicated the provider spoke with R35 regarding trialing discontinuation of the Foley catheter and would discuss it further at her regulatory provider visit in March 2024.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R35's March 2024 provider visit note lacked any evidence of discussion regarding a trial discontinuation of R35's Foley catheter and indicated, previously discussed trial without Foley catheter as it was initially placed for dysuria and not obstructive uropathy. admitted ly, did not revisit today.<br><br>During an interview and observation on 7/15/24 at approximately 5:00 p.m., R35 was laying in bed with a Foley catheter bag hanging at bedside. R35 stated she had the catheter for years due to it being painful when she urinated and developing chronic UTIs. R35 did confirm she has had multiple UTIs with the catheter in place.<br><br>During an interview on 7/18/24 at 11:06 a.m., the nurse manager and registered nurse (RN)-D stated she spoke with the provider who admitted ly did not discuss removal of the Foley catheter as she believed R35 would refuse, stating R35 had adamantly refused to remove the catheter in the past. RN-D further confirmed that since the catheter was placed in 2021, they had not attempted a trial removal, stating it relieved her symptoms of painful bladder spasms when it was placed. RN-D stated R35 was having some symptoms of dysuria with the catheter in place so it was discussed to potentially remove it however R35 would not allow it.<br><br>During an interview on 7/18/24 at approximately 12:30 p.m., the director of nursing (DON) stated she understood the importance of having medical justification for long standing Foley catheter use and would work with the provider or R35's urologist on proper justification for keeping the Foley catheter in place.<br><br>A facility policy titled Urinary Indwelling Catheter Insertion and Management, revised 6/25/24, indicated all residents with an indwelling catheter require a medical justification for the initiation and<br><br>continuing need for catheter use. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495<br><br>Based on interview and document review, the facility failed to assess and reassess what, if any, non-pharmacological pain interventions would be helpful and accepted by 1 of 1 resident (R95) to supplement medication management of chronic pain continually rated severe and described as frequently interfering with sleep and daily activities.<br><br>Findings include:<br><br>R95's quarterly Minimum Data Set (MDS), dated [DATE], indicated R95 was cognitively intact with frequent pain rated as 8/10 that frequently affected his sleep and interfered with therapy and day to day activities.<br><br>R95's Diagnoses list, dated 5/29/20, indicated R95 had several medical diagnoses including chronic pain syndrome and opioid dependency.<br><br>R95's physician orders, indicated R95 had the following medication orders; cyclobenzaprine (a muscle relaxer) 10 milligram (mg) one tablet by mouth three times a day (TID), hydrocodone-acetaminophen (a narcotic pain medication used to treat pain) 5-325 mg one tablet by mouth twice a day and two tablets by mouth once a day, Lyrica (used to treat nerve pain) 25 mg two capsules once a day, meloxicam (a nonsteroidal anti-inflammatory drug often used to treat arthritis pain) 15 mg one tablet by mouth TID, Suboxone (contains the opioid buprenorphine, it has some pain-relieving effects and may help chronic pain patients with an opioid use disorder manage their pain as well as their withdrawal symptoms) 8-2 mg one film sublingual (under the tongue) TID. R35's physician orders further indicated an order to monitor pain: please document signs/symptoms of pain if any and the non-[NAME] [non-pharmacological] intervention that was used every shift.<br><br>R95's pain assessment, dated 5/12/24, indicated R95 received scheduled and as needed pain medications and frequently had pain rated as severe that frequently interfered with sleep and daily activities. The pain assessment indicated via check box that R95 had received non-pharmacological pain interventions however lacked any documentation of what was used or accepted by R95 and what worked or did not in helping decrease R95's pain.<br><br>R95's pain assessment, dated 2/18/24, indicated the same responses as the pain assessment dated [DATE], indicating no improvement or change in R95's pain.<br><br>R95's medication and treatment administration record indicated R95 had pain rated as 8/10 or higher on 70 shifts (three per day) in the past 30 days.<br><br>R95's progress notes, dated 4/1/24 - 7/17/24, were reviewed and lack any evidence of attempted, or offered, non-pharmacological pain interventions to supplement pain medication in an attempt to help relieve R95's chronic pain. R95's progress notes further indicated R95 had five falls on 4/26/24, 5/4/24, 7/7/24, 7/13/24, and 7/17/24.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R95's care plan, dated 6/18/2020, indicated R95 had actual alteration in COMFORT r/t [related to] OA [osteo arthritis] of (L) [left] knee, morbid obesity, chronic pain. Resident takes scheduled and PRN pain interventions. History of high pain rating, provider aware. Followed by pain clinic. Interventions on R95's care plan had not been revised since 6/18/202 and included monitor level of comfort and notify provider if pain is not adequately managed with current interventions, pain medications as ordered and non-pharmacological interventions: offer positioning, warm blanket, ice pack, emotional support, toileting, drink, snack, activity, TV show, movie.<br><br>R95's electronic medical record (EMR) further lacked a comprehensive assessment and reassessment of what, if any, non-pharmacological pain interventions R95 would accept or were successful in helping to relieve R95's pain despite chronic pain continually rated as severe.<br><br>R95's pain clinic notes indicated R95 was seen in the pain clinic monthly since 12/6/23. The pain clinic notes indicated no changes to R95's current pain regiment on 12/6/23, 2/7/24, 4/3/24, 5/1/24, and 7/1/24, and lacked any non-pharmacological pain interventions. Medication was adjusted on 1/10/24, and 6/3/24, when Meloxicam was increased.<br><br>During an interview on 7/17/24 at 8:08 a.m., nursing assistant (NA)-B stated R95 had been having more falls lately because his knees were getting weak and buckling causing him to fall. NA-D stated R95 did not complain of pain to her however she often observed him asking the nurses for pain medication.<br><br>During an interview on 7/17/24 at 8:26 a.m., R95 was sitting up in his electric wheelchair and stated he continued to have severe pain despite working with the pain clinic. He stated they started him on Suboxone which was supposed to take his pain down but it doesn't despite being on it for more than six months. R95 stated his most severe pain was in his knees and tailbone and that he felt a little bit of relief when he could lay in bed to get the weight off of his tailbone. R95 stated his pain was currently a 7/10 and was usually around an eight after being up for the day. R95 further stated he understood he would not be completely pain free but would be comfortable if his pain could decrease to about 4-5/10 and indicated that nobody had assessed what is pain goal was. R95 had his computer open and was currently searching for a new cushion for his wheelchair to see if that would give him any relief. He further stated he was open to trying different non-pharmacological pain interventions such as aromatherapy or massage however staff had never asked him what made the pain better or worse or what he was willing to try, stating that staff only asked what his pain level was. R95 indicated he used to ride the stationary bike to try to keep his strength up however the pain in his knees had gotten worse and he could not do it anymore, leading to increased weakness and falls. R95 stated he was going to be starting therapy soon.<br><br>During an interview on 7/17/24 at 11:04 a.m., registered nurse (RN)-G stated R95 would often report pain however he does not show pain and that staff gave him pain medication as ordered and R95 did not have any as needed pain medication to keep it black and white since he was an addict and would often seek pain medication. RN-G stated in the past, they had tried ice, a warm blanket or offered to lay R95 down however it, always had to be his pain pills. RN-G stated if a non-pharmacological pain intervention had been attempted, it would have been indicated in a progress note however there was no documentation of what had been attempted, what had worked and what had not worked.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 7/18/24 at 8:48 a.m., nurse manager and registered nurse (RN)-D stated the pain clinic manages R95's pain and pain medication, stating they got the pain clinic involved in R95's care because he never backs off of his pain scale and is always wanting more pain medication. RN-D stated she allowed the nurses to complete their own assessment of R95's pain however his facial expressions did not match his verbal description of pain. RN-D stated if a non-pharmacological intervention was used it would have been identified in a progress note or a physician order. RN-D stated R95 was his own worst enemy and was using the stationary bike however lately, had been refusing to use it, refusing to ambulate and refusing therapy.<br><br>A facility policy titled Pain Management, revised 10/14/22, indicated the pain management program was based on a facility-wide commitment to resident comfort. Pain Management could include any of the following measures: assessment, root cause analysis, pharmaceutical and non-pharmaceutical interventions and follow up of effectiveness of PRN pharmaceutical interventions. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925<br><br>Based on interview and document review, the facility failed to ensure identified dental concerns (i.e., loose dentures, need for appointment) were acted upon and, if needed, referred to the appropriate resource in a timely manner for 2 of 2 residents (R106, R65) reviewed who voiced dental complaints during the survey.<br><br>Findings include:<br><br>R106<br><br>R106's admission Minimum Data Set (MDS), dated [DATE], identified R106 had intact cognition and demonstrated no delusional thinking. Further, the MDS identified a section labeled, L0200, along with spaces to record broken/loose-fitting dentures, cavities, or mouth pain. This was answered, None of the above were present. Further, R106's Census listing, printed 7/18/24, identified R106's current payor source listed, Medicaid MN, with an effective date, 05/10/2024.<br><br>On 7/16/24 at 8:33 a.m., R106 was interviewed. R106 stated she admitted to the care center a few months prior and had some unresolved concerns with her dentures. R106 explained she used an upper denture which doesn't fit along with a bottom plate which had seemingly shrunk into my gum. R106 stated the misfitting dentures had been an issue for a long, long time and, at times, caused trouble chewing for her. R106 stated nobody from the care center had asked her about her dentition or what, if any, dental services or appointments were available or wanted. R106 added the loose dentures had been really tricky to deal with lately.<br><br>R106's Nursing Admission, dated 4/24/24, identified R106 admitted from the hospital on the same date along with a section labeled, Oral/Dental, which contained spaces to record what, if any, dental concerns were present. This identified R106 had her own teeth on the lower palate along with an upper denture. The assessment, again, marked None of the above were present, for the various dental conditions as outlined on the MDS. The form lacked any spacing to record what, if any, dental services were explained or offered at the time; nor was there spacing or dictation to record when R106's last dental examination had been.<br><br>However, R106's progress note, dated 4/26/24, identified the following, NUTRITION: Initial Visit . Oral/Dental status: Res has upper denture and natural lower teeth. Per [R106], upper denture is poor fitting but easily adjusted w/ [with] denture glue. Res notes some difficulty w/ chewing [due to] poor dentition, however res denies pain/difficulty . offered foods cut into bite size pieces w/ extra gravy/sauce . res is agreeable to. Diet order updated accordingly. SLP notified of chewing concerns. The note lacked evidence R106 had been offered any dental appointment to have the dentures evaluated.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R106's Care Conference Summary, dated 5/2/24, identified R106's initial care conference was held with R106 in attendance. A section of the summary was labeled, Ancillary Services offered (Check all that apply, which provided spaces to record what, if any, services were offered including dental. However, this was answered with, Not applicable (indicate reason) - na. A subsequent section outlined a checkmark placed adjacent to, Declined all ancillary services. The completed summary lacked evidence which of these conflicting answers (i.e., NA versus declined) was accurate; nor if R106's identified loose-fitting denture had been discussed.<br><br>A subsequent progress note, dated 5/6/24, identified R106 was seen again for a nutritional review and the note outlined, Res notes some difficulty w/ chewing during initial [staff] visit, which res relates to poor dentition. No chewing/swallowing concerns noted. However, again the note lacked evidence R106 had been offered any dental appointment to have the dentures evaluated.<br><br>R106's care plan, last revised 6/27/24, identified R106 required assistance with activities of daily living (ADLs) due to her past medical history and condition. The care plan identified an intervention which read, ORAL CARE: Staff to provide assist with oral care. However, the care plan lacked any further dictation or interventions for R106's dental status or condition despite R106 being identified to have poor-fitting dental appliances by the nutrition review.<br><br>When interviewed on 7/16/24 at 1:27 p.m., nursing assistant (NA)-A stated they had worked with R106 a few times since she admitted to the transitional care unit (TCU). NA-A explained R106 needed some help with cares but completed oral cares on her own adding R106 had her own teeth. NA-A stated they were unaware R106 had complaints of a loose-fitting denture but expressed last week they had noticed R106 had a swollen lip which they reported to the nurse. NA-A stated they were unsure what caused the swollen lip. Further, NA-A stated any dental appointments would be scheduled through the nurse managers or the health unit coordinators (HUC).<br><br>R106's medical record was reviewed and lacked evidence the loose-fitting denture had been acted upon and discussed with R106 to determine what, if any, services were wanted or needed; nor if it had been referred to a dental provider despite R106 reporting the denture caused trouble with chewing.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/17/24 at 10:00 a.m., registered nurse unit manager (RN)-A was interviewed and verified they had reviewed R106's medical record and spoken to the social worker (SW) about R106's dental status. RN-A explained when a resident admitted to the TCU, they were typically there for only a short time so it was difficult to get them referred to the in-house service for dental needs as they were onsite only quarterly. However, RN-A stated if concerns were expressed by the resident or identified, they could get a referral sent and arrange an outside appointment, if needed. RN-A stated the nurses who evaluated a resident's dentition could also notify them or social services if concerns were identified. RN-A stated neither them or the social worker were aware R106 had a loose-fitting denture (as identified in the progress notes) and verified the dietary staff who authored the notes had not passed the information onto them. RN-A stated if they had been told of it, then a referral would have been placed and help provided to R106 to set-up a dental appointment with an outside service. RN-A stated the author of the note had verbally reported (just prior when asked about it due to surveyor inquiry) R106 stated she did not want any action taken with it, however, RN-A acknowledged the lack of documentation in the medical record to support such adding, I would have documented that personally. RN-A verified R106's medical record lacked evidence the loose-fitting denture was acted upon to determine what, if any, services were wanted or needed adding, No, not that I see. RN-A reviewed R106's Care Conference Summary and acknowledged the recorded response of 'NA' under ancillary services. RN-A stated the social worker, to her recall, did not routinely offer dental appointments or referrals at the time of these conferences to TCU-based residents. Further, RN-A stated it was important to ensure dental issues, such as loose-fitting dentures, were acted upon timely to ensure no oral discomfort and proper nutrition was maintained.<br><br>49339<br><br>R65<br><br>R65's significant change MDS assessment, dated 5/22/24, indicated R65 had intact cognition and demonstrated no delusional thinking. Further, the MDS identified a section labeled, L0200, along with spaces to record no natural teeth or tooth fragments(s) (edentulous). This was answered, None of the above were present. Further, R65's Face Sheet, printed 7/18/24, identified R65's current payor source listed as, Medicaid MN.<br><br>On 7/16/24 at 8:32 a.m., R65 was interviewed and stated, I don't have any dentures .I would like dentures. R65 explained they haven't talked to me about dentures. R65 further clarified that nursing staff or social workers at the facility have not talked to her about dentures and indicated she has not had dentures since being in the facility.<br><br>R65's Chart Progress Note dental visit, dated 2/27/24, indicated R65 was seen for dental exam and expressed interest in dentures. Note indicated, We discussed the options of traditional dentures vs implant supported dentures vs no treatment She states she is interested in plant supported dentures. Note further indicated, We have referred [R65] to our Mounds View office for a consult re: [regarding] implant supported dentures.<br><br>R65's Care Conference Summary, dated 3/14/24, indicated a quarterly care conference was completed and a radio-button answered yes to R65, and family invited and attended care conference. Under ancillary services section, indicate approximate date of last visit- Last dental visit date, indicated see resident documents. The document lacked any information about dentures or follow up on dental visit from 2/24.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R65's Care Conference Summary, dated 6/2/24, indicated a quarterly care conference was completed and a radio-button answered yes to R65, and family invited and attended care conference. Under ancillary services section, indicate approximate date of last visit. Last dental visit date, indicated see resident documents. The document lacked any information about dentures or follow up on dental visit from 2/24.<br><br>A review of R65's progress notes, dated 1/2/24 to 7/17/24, lacked evidence of reference to dental appointment in February 2024.<br><br>On 7/17/24, a progress note indicated, in discussion with resident and resident's spouse, resident and spouse endorsed together that they do not wish to pursue dentures/implants at this time. This was after surveyor inquired about status of dentures and appointment follow up for R65.<br><br>R65's care plan, printed 7/16/23, identified R65 required assistance with activities of daily living. The care plan identified an intervention which read, ORAL CARE: Staff to provide assist with oral care. However, the care plan lacked any further dictation or interventions for R65's dental status or condition.<br><br>R65's medical record was reviewed and lacked evidence of coordination after dental appointment and R65's desire to obtain dentures.<br><br>On 7/17/24 at 2:20 p.m., registered nurse unit manager (RN)-F indicated the process for getting a resident seen for dental is social services obtains the consent signed, which is then sent to the dental provider. They [dental provider] determined who they were going to see at the visits and came every couple of months. RN-F stated if there is an urgent need or concern, they can be seen sooner. After reviewing documentation, RN-F indicated that it looks like [R65] was referred to another dental clinic which they were going to follow up with.<br><br>On 7/18/24 at 8:10 a.m., RN-F indicated they had a conversation with [R65] and her husband about dentures, they only want implants, and did not want to go back and forth with appointments and have decided to not proceed. RN-F stated that this was an elective procedure for R65. RN-F stated the current process for paperwork received from onsite dental visits was the paperwork was sent to the facility, given to the nurse manager on the floor who reviewed, completed follow up as indicated and then placed in the chart. RN-F indicated this has been the process since they had been there and added, I was not employed here when she was seen by the dentist. R65 verified there was no progress notes in R65 regarding follow up appointments for dental appointments.<br><br>On 7/18/24 at 10:08 a.m., RN-F indicated they followed up with onsite dental provider and was informed that an appointment was made for R65 at the other clinic after the referral was made, the care coordinator (at the dental provider) was unable to provide information as to who was notified about the appointment.<br><br>On 7/18/24 at 10:25 a.m., family member (FM)-C indicated that they are involved with R65's care and visit often. FM-C confirmed the facility had not talked to them until yesterday (7/17) about R65's desire for dentures. FM-C indicated R65 had talked about wanting dentures around the beginning of the year.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245264 | A. Building<br>B. Wing | 07/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Valley Village Health Care Center | 14650 Garrett Avenue<br>Apple Valley, MN 55124 |

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

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|---|---|
| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/18/24 at 11:11 a.m., director of nursing (DON) stated they had a dental provider that provided onsite services routinely. She stated social services obtained consents and the dental visit notes were uploaded into the chart. DON further indicated the facility was not notified of R65's referral appointment being made as an order would have been entered with a time and date and there was no order for it.<br><br>The facility was unable to provide any documentation to support that facility was involved or aware of follow up needed from February dental appointment prior to survey.<br><br>A facility policy titled Ancillary Services, reviewed 2/12/24, was provided. The document indicated social services staff or designee would meet with resident or their representative upon admission and identify needs and goals for obtaining care from Ancillary service providers and then obtain information from the last dental visit. Further indicated health information staff or designee with schedule appropriate appointment per facility procedures and social service staff or designee would document the resident's plan for ancillary health care services in resident's care conference summary form. Ancillary services were reviewed with each care conference and updated when requested by resident/resident representative. |