STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48037 Based on observation, interview and document review the facility failed to comprehensively assess pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in potential harm when 1 of 1 residents (R1)'s wound was not comprehensively monitored or cleaned. Findings include R1's Face Sheet, identified R2 had diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke) and fracture of T7-T8 vertebra. R1's Admission data collection dated 8/23/24, identified R1 arrived at facility on 8/23/24 at 12:00 p.m. R1 required total dependance for transfers from two or more staff. The skin assessment identified R1 had redness to mid upper vertebrae, redness to groin, and left buttock pressure ulcer, and both heels were red. The assessment indicated treatment(s) and monitoring had been set-up. R1's record did not include comprehensive assessments of the areas of impaired skin integrity that included further description, stage of ulcer(s), measurements, and any associated pain. R1's care plan dated 8/24/24, included R1 had alteration in skin integrity related to bruising on bilateral upper extremities, redness in groin and upper mid vertebrae, discoloration of front of right knee, pressure on left buttock. Staff were to monitor skin integrity daily during cares. Weekly skin inspection by nurse. Monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to medical doctor or physician assistant, certified (PA-C). R1's physician orders dated 08/24/24, included the following: -Monitor scattered bruises on bilateral upper extremities for any signs of pain and infection until healed-every shift. -Monitor resident pressure sore on the left bottom for any signs of pain and infection until healed. -Monitor reddened bilateral heals until healed every shift. -Monitor redess to groin until healed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's treatment administration record (TAR) identified the aforementioned treatment orders. The documentation indicated the treatments were completed by check marked boxes with no other information aside from the staff intials who completed the documentation. R1's progress note dated 8/24/24 at 12:57 p.m., identified R1's skin was warm/dry, had surgical wound to back and did not have open wounds. Treatment to wound performed on shift as ordered. No further description was given. R1's progress note dated 8/24/24 8:54 p.m. identified Skin was warm/dry. Additionally note indicated No surgical wound noted. Turned and repositioned frequently. Offloading of affected area. Skin treatments performed as ordered. R1's progress note dated 8/24/24 1:56 p.m., identified Skin was cool and clammy.Additionally note indicated no surgical wound noted. No open wounds noted. Turned and repositioned frequently. Free from signs and symptoms of pain. R1's progress note dated 8/25/24 at 11:36 p.m. identified Skin is warm/dry. Additionally note indicated no surgical wound noted. No open wounds noted.Turned and repositioned frequently. Offloading of affected area. R1's progress note dated 8/26/24 12:36 p.m., identified Skin is warm/dry. Additionally note indicated No surgical wound noted. No open wounds noted. Turned and repositioned frequently. Offloading of affected area. Free from signs and symptoms of pain. Client Coordination note report from the hospice team dated 08/26/24 identified resident chose not to admit to hospice services. R1 does not ambulate or transfer and is bed bound. Skin was identified to have a coccyx wound. The note did not include a comprehensive assessment of the wound. R1's care plan dated 8/26/24 identified, R1 was on enhanced barrier precautions due to surgical incision, pressure sore on left bottom. Staff were to monitor skin integrity daily during cares Weekly skin inspection by nurse. Report signs symptoms to medical doctor (MD) or physician assistant. R1's progress note dated 8/27/24 4:01p.m. identified Skin is warm/dry. Additionally note indicated no surgical wound noted. No open wounds noted.Turned and repositioned frequently. Offloading of affected area. R1's Nurse practitioner note dated 8/27/24, identified R1 as a new patient. Skin inspection identified no rashes or ulcers. R1's progress note dated 8/28/24 at 12:28 p.m., Skin is warm/dry. No surgical wound noted. No open wounds noted. Turned and repositioned frequently. Free from signs and symptoms of pain. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Hospital note dated 08/29/24 at 2:14 a.m. identified while providing care to R1 writer noted a wound on his left buttocks. See chart for picture. The picture that was included identified a large unstageable oblong pressure ulcer that covered almost all of R1's left buttock. The ulcer base was approximately 95-98% black eschar, with yellowish slough surrounding the top 1/2 of the eschar, the entire wound periphery was red. Approximately 2-5% of the wound bed was red with one small fluid filled blister located within the wound periphery. The note further indicated R1 was taken to the medical surgical floor and given a shower. Barrier cream applied to his wound on his buttocks. Signed at 2:22 a.m. hospital note at 8:02 a.m. hospital registered nurse (RN)-D reported R1's family friend had called for an update and had reported the facility had informed them the wound was healing well. During a return call interview from 9/6/24 at 2:12 p.m., RN-D reported R1's left buttock wound was identified by the overnight RN from 8/28/29 to 8/29/29. RN-D indicated the facility had not informed the hospital of R1's buttock wound upon or after the transfer to the hospital. RN-D described the wound as a stage three pressure ulcer from the top of R1's buttocks down to the bottom. The eschar tissue is noted to be black with not a lot of drainage. Yellow crust on the outside on the outer edge. Scar tissue starting to form on the outside of the wound. There may have been a open area on the outer left side. Approximation of size was at least 15 centimeters (CM) by 8.0 or 9.0 cm. During interview on 9/4/24 at 9:03 a.m. family member (FM)-A reported concerns for R1's care while in the facility. FM-A was concerned of the wound located on R1's left buttock and would ask staff how the wound was healing; staff reported the wound was healing and doing really good. Once R1 arrived at the hospital on 8/28/29 hospital staff were concerned regarding the size and coloring of the wound. Hospital staff reported to the family R1's wound was not healing. During interview on 9/6/24 at 3:30 p.m., registered nurse (RN)-B stated he/she completed R1's admission and completed the skin assessment. R1 had a pressure ulcer upon admission on the left buttock that was approximately 5.0 cm by 5.0 cm with some black/purple eschar. RN-B recalled doing the skin assessment and notifying management per the facility's wound care policy. RN-B did not recall if R1 had orders from the hospital for wound cleaning and R1 did not call to clarify orders regarding wounds. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A stated he/she was familiar with R1. On 8/24/24, NA-A recalled R1's bottom to be red but did not remember any ulcers and would consider the skin to be normal otherwise. NA-A stated R1 had ongoing diarrhea and used barrier cream to protect the skin. NA-A stated she would reposition/offload a couple of times a shift but R1 did not have a specific repositioning/off-loading schedule. During interview on 9/5/24 at 2:30 p.m., nursing assistant (NA)-B stated he/she assisted NA-A with changing R1 on 8/24/24 and did not recall any sores but R1's bottom was red because of diarrhea. They applied a lot of barrier cream During interview on 9/5/24 at 1:54 p.m., registered nurse (RN)-A stated no recollection of R1 having an unstageable wound on his left buttock and only recalled his bottom being red. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview nurse manager (NM)-A 9/5/24 at 12:38 p.m., nurse manager (NM)-A indicated she participated in wound rounds which were completed weekly. Since R1 was only in the facility for five days so R1 was not seen by the wound nurse on wound rounds. NM-A reviewed R1's record and confirmed the admission record identified a left buttock pressure ulcer and there was not a comprehensive pressure ulcer assessment completed. NM-A indicated it was not possible to ascertain the size of the ulcer upon admission and not possible to identify if the ulcer had deteriorated or improved because there was not a description, or measurements recorded. NM-A indicated pressure ulcers were supposed to be comprehensively assessed upon identification and then weekly. Additionally, wounds should be routinely monitored for changes. During interview on 9/6/24 at 12:58 p.m. nurse practitioner (NP)-A reported R1 had a wound on his buttocks, however never visualized it. Typically, if there was a concern about a wound, a specialized wound nurse practitioner would do a full skin assessment. NP-A was not notified about any concerns regarding the wound. NP-A reported R1 was in the facility less than a week and R1 may have missed the wound care rounding. NP-A was unable to locate measurements of the left buttock wound upon admission, was not able to locate a monitoring order for R1's wound, there was no documentation of monitoring from 8/24/24 through 8/28/24 and did not locate any treatment orders. The goal for monitoring wounds was to identify if it was getting better or worse. NP-A indicated wounds when identified should be comprehensively assessed to include the stage and measurements to determine if the wound is worsening or improving. During interview on 9/5/24 at 3:20 p.m., director of nursing (DON)-B reviewed R1's record and confirmed the admission skin assessment identified pressure ulcer on R1's left buttock. DON-B stated based on the assessment there should have been treatments orders however, R1's records did not have any treatment orders for the left buttock wound. During interview on 9/6/24 at 1:15 p.m., director of nursing (DON)-A reported she had not ever visualized R1's buttock and had not ever met R. DON-A reported if there were any concerns DON-A would report to NM-A for R1 to be seen for wound rounds. DON-A indicated an unawareness R1 had a pressure ulcer on his left buttock. During interview with administrator on 9/6/24 at 2:05 p.m., administrator reported its the facilities responsibility to prevent or mitigate the risk of pressure sores and possible wounds. Skin assessment and wound management policy dated 3/2024 identified the purpose is prevention and identification to Provide guidelines for assessing and managing wounds. 1) a pressure ulcer risk assessment (Braden Scale) will be completed per monarchs assessment schedule/grid. 2) implement appropriate preventive skin measures. Examples include, but are not limited to, nutrition interventions, mobility and repositioning plan, pressure redistribution plan. 3) Skin evaluation and skin risk factors form was to be completed prior to the initial MDS, annually and upon significant change. 4) Staff were to provide routine skin inspections (with daily care). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5)Nurses to be notified if skin changes are identified. 6) A weekly skin inspection will be completed by licensed staff. Pressure wounds: New skin problems: when a pressure ulcer is identified, the following actions will be taken: 17. notify provider/treatment orders 18. notify resident representative 19. complete education with resident/resident representative including risk and benefits. 20. Initiate skin and wound evaluation 21. notify nurse manager/wound nurse 22. Referral to dietary 24. review and update care plan including interventions 25. update resident care lists 26. update care plan to identify risk for skin breakdown. Ongoing skin isses: -update provider and resident/representative as needed. - update care plan as needed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 48037 Based on interview and document review the facility failed to complete comprehensive fall analysis to determine accurate causal factors and implement appropriate care plan interventions to prevent or mitigate the risk of recurrent falls for 1 of 3 residents (R1) reviewed for falls. The facility's failures resulted in actual harm when R1 fell and sustained an acute nondisplaced fracture involving sacral (tailbone). Findings include: R1's Face Sheet, undated, identified R2 had diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (stroke) and fracture of T7-T8 vertebra (thoracic area of back). R1's Admission data collection tool dated 8/23/24, identified R1 arrived at facility on 8/23/24 at 12:00 noon. R1 was not cognitively intact. R1 was assessed for pain with non-verbal sounds (e.g. Crying whining, gasping, moaning or groaning). Vocal complaints of pain (e.g. that hurts, ouch, stop), protective body movements (e.g. bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). R1 was totally dependent on two or more staff for transfers. R1's orders dated 8/23/24 direct R1 to wear back brace (TLSO) during showers, no lifting greater than 10 lbs. , wear brace for three months, when head of bed is greater than 30 degrees and this includes when resting in bed, sitting and walking. Avoid excessive, bending, twisting or turning. Monitoring for falls was added on 8/28/24. R1's care plan dated 8/23/24, identified a fall risk related with the intervention for staff to monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes and after remove any potential cause if possible. Educate resident/family/caregivers/ interdisciplinary team as to causes. There was no interventions identified to reduce R1's risk of falls. R1's fall incident report dated 8/23/24 at 8:00 p.m., indicated R1 had an unwitnessed fall. R1 was found face down in between the bed and window with his back brace lying on the bed. R1 was pleasantly confused, orientated to person, and was not able to answer the nurse's questions. R1 moaned in pain when repositioned. Immediate action taken: resident transferred from floor to bed using a full body mechanical lift. Skin check completed no new injury noted, No changes from range of motion from the time of admit. Temperature 100.1 (normal 97-99 degrees Fahrenheit), pulse 103 (normal 60-100), respirations 19 (normal 12-18), blood pressure 138/82 (normal 90/60 to 120/80 mmHg), oxygen at 92% (normal 95-100%) on room air. The on call provider was notified and new order to send R1 to the emergency room for further evaluation. Predisposing environmental factors included medical device (bed, wheelchair, cords etc.) Resident removal of safety devices. Predisposing physiological factors include change in behavior, confused, forgetful, unsteady gait, gait imbalance, and impaired memory. Predisposing situation factors include new admission and rolled out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 8/24/24, identified R1 returned to the facility after the emergency room (ER) visit at 3:30 a.m. Document titled Incident Review and analysis dated 8/26/24, identified the R1's fall on 8/23/24 at 8:00 p.m. and indicated the interdisciplinary team (IDT) reviewed the fall. The review indicated staff noticed R1 had increased pain, R1 was not incontinent at the time of the incident, there were no cords R1 could have tripped on, and the call light was within reach when R1 was in bed. Contributing factors included: R1 was new admission, was confused, had an unsteady gait, forgetful, unable to realize limitations. The section for current intervention in place directed see care plan and the section Possible interventions and Other Interventions was left blank. Although R1's record identified potential causal factors, it was not evident further analysis was completed to identify interventions that addressed R1's contributing risk factors of R1's not recognizing own limitations, confusion, impaired memory, unsteady gait, and forgetful. R1's care plan dated 8/26/24 identified intervention added on 8/23/24 environmental changes to room: bed position change. During interview on 09/06/24 at 3:30 p.m., registered nurse RN-(B) reported to be the admitting nurse for R1 and aware of R1's fall history prior to admission. RN-B also the nurse who found R1 on the ground on 8/23/24 reported R1 was located face down between the bed and the window, his back brace was on the bed. R1 was incontinent of bowel movement (which was inconsistent with the 8/26/24 Incident Review report). RN-B reported R1's care plan was not followed as R1 did not have TLSO brace on at time of the fall. R1 went to hospital due to unwitnessed fall and pain, arrived back at the facility at 3:30 a.m. with no injuries. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)-A reported R1 was a major fall risk when he was admitted and checked on him frequently because of that. NA-A would use a lot of pillows on both sides of him when he was in bed to prevent him from falling. R1 was supposed to have a concave mattress but did not. NA-A recalled on 8/24/24 between 6:00 and 6:45 a.m. she had been walking past R1's room and saw R1 off the edge of the bed with a hand on the ground and foot nearly touching the ground demonstrating the shape of a star fish with his back against the side of the bed. NA-A communicated to RN-A who entered the room, they boosted R1 back to bed. Not long after the near miss fall around 7:00 a.m. NA-A went to check on R1 and found him on the floor. R1 was incontinent. NA-A was unsure if R1 hit his head so she had RN-A assess R1 and NA-B assisted with putting four to five pillows on each side of R1. NA-A thought that was the best course of action to secure R1 in bed. After the fall R1 had been moaning a little during the day. NA-A indicated the intervention to use pillows was not part of the care plan until a few days later. During interview 9/5/24 at 1:54 p.m., RN-A stated he worked on 8/24/24. RN-A stated the first incident was a near fall where he was partially on the floor and then he was found on the floor a short time later. RN-A stated anything he did that day would be documented in the medical record. During interview on 9/5/24 at 2:30 p.m., nursing assistant (NA)-B worked the morning of 8/24/24. NA-B stated R1 had fallen because she assisted NA-A to transfer R1 off the floor and into bed. R1 was incontinent at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During on 9/5/24 at 1:45 p.m., NA-A and DON-A reviewed circumstances of a fall and NA-A confirmed this had happened on her shift of 8/24/24. DON-A reported the facility was unaware of the first incident as RN-A never reported the fall. R1's Mobility assessment dated [DATE] identified, R1 required substantial/maximal assistance for rolling left and right, substantial/maximal assistance for sitting to lying. R1 was dependent to wheel 50 feet with two turns in a manual wheelchair. R1's fall incident report dated 8/28/24 at 9:35 a.m., indicated R1 had an unwitnessed fall in his room at 9:30 am. R1's call light had been on when staff found R1 on the floor lying on his left side near his bed with his back brace on. R1 denied hitting his head and pain. R1's vital signs: blood pressure 103/93, pulse 113, respirations 18, and blood glucose 170 (normal 70-99 mg/dl). No injuries noted at the time of the incident, pain level was zero, and R1 was alert to person however confused. Predisposing physiological fall risk factors included: history of falls, not always able to realize limitations, narcotics, and anticoagulant (blood thinning medication). Predisposing situation factors was blank. The immediate intervention directed staff to use a body pillow while in bed. The physician, administrator, family were notified at 11:23 a.m.-11:28 p.m. R1's incident report dated 8/28/24 at 10:45 a.m., indicated R1 had an unwitnessed fall at 10:45 a.m. The report indicated R1 had appeared to roll out of bed and was found on the floor lying on his back with his back brace on. R1 reported he had not hit his head, denied pain, and no injuries were observed. R1 was confused and his urine appeared to be dark in color compared to baseline. The body pillow was in place and the care plan followed at the time of the fall. Predisposing physiological fall risk factors included: anticoagulant, not always able to realize limitations, and narcotics. The physician, administrator, family were notified at 11:35 a.m.-11:36 p.m. Immediate action identified was a physician order to send R1 to the hospital for altered mental status and multiple falls. Document titled Incident review and analysis dated 8/28/24, identified the aforementioned fall information with additional information that included the IDT reviewed the incident. Further included the contributing factors was documented as R1 had recent hospice consult, R1 BIMS of 0 (indicating severe cognitive impairment). R1's records did not include a comprehensive analysis for individualized fall interventions that addressed R1's contributing risk factors such as (but not limited to) R1's not recognizing own limitations, confusion, severe cognitive impairment, and narcotic pain medication. R1's care plan was updated on 8/28/24 with the intervention of Body pillow when resident is in bed to prevent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's hospital record dated 8/28/24, indicated R1 arrived via ambulance at 12:01 p.m. for urgent admission following two unwitnessed falls from his bed today (8/28/24). The note indicated the need for further evaluation because R7 had recent thoracic spine fracture (T7), was on a Plavix therapy (blood thinner), and had a potential head strike. R1 was alert, but unreliable historian, somewhat confused, and had back pain. R1's neurological exam was listless, low level of interactivity and R1 was only able to answer yes or no questions. CT (computed tomography) identified R1 had an acute nondisplaced fracture involving an anterior marginal endplate osteophytes at S1 with questionable extension into the vertebral body anterior. Further lab tests identified R1 had have worsening leukocytosis (high white blood cells), abnormal urine analysis (UA), COVID 19 positive, evidence of dehydration, and abnormal liver function tests (LFT's). Plan for transfer for further evaluation and treatment following imaging. During interview on 09/04/24 at 9:03 a.m., R1's medical power of attorney (POA) indicated upon admission they made the facility aware R1's fall history and were concerned with the level of supervision the facility had been providing. POA stated the facility had called them on 8/23/24 at 11:46 to report R1 had a fall out of bed. Then on 8/28/24 at 2:45 p.m. the facility had called to inform them R1 had two falls and was transferred to the hospital. POA stated R1 was hospitalized for an additonal fracture in his spine. During interview on 9/6/24 at 1:37, p.m. nurse manager (NM)-A indicated she had worked on 8/28/24 when R1 rolled out of bed twice. NM-A was not sure if R1 was crawling out of bed or if he had rolled out of bed and why R1 would be trying to get out of bed. NM-A explained she had implemented the intervention of the body pillow after the first fall with the goal of reducing the risk of R1 rolling out of bed, however NM-A did not complete an assessment to determine if the pillow would be effective and/or appropriate. During a subsequent interview on 9/4/24 at 2:27 p.m., Nurse manager NM-A explained after resident falls the nurse immediately completes an assessment for injuries then the nurse completes a checklist. Nurses are expected to document the fall, complete a causal analysis, and determine and immediate intervention to prevent recurrent falls. The IDT then meets to complete the comprehensive analysis and evaluate for any further fall interventions. The expectation was to immediately notify director of nursing (DON), physician, and family. On 9/5/24 at 10:50 a.m., a group interview was held with administrator, NM-A, DON-A, DON-B, regional manager (RM)-A (on phone) and regional director of operations (RD)-A (on phone). DON-A reviewed R1's falls and indicated the fall that occurred on 8/28/24 at 9:35 a.m. staff should have started neurological assessments. The fall was unwitnessed and was not known if R1 hit his head even though he reported he did not; he was not a reliable historian because he had severe cognitive impairment. R1's level of supervision was not increased to prevent or reduce his risk for falls. R1 was sent to the hospital following the second fall due to being worried about his safety, altered mental status, and signs of infection. First immediate intervention to prevent falls was environmental and moving the bed following the fall on 8/23/24 at 10:00 p.m., Second fall on 8/28/24 at 9:35 a.m. with a second immediate intervention was a body pillow and the third fall on 8/28/24 at 10:45 a.m. R1 was sent to the hospital and did not return. Facility staff were not aware of a 8/24/24 when R1 was found half out of bed, almost on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled fall prevention and management dated 2/2024, identified nursing staff are to complete a fall risk evaluation to identify and document risk factors for falls upon admission, annually, with a significant change in condition, and as needed. Facility staff will identify interventions related to the residents specific risks and try various interventions, based on the nature or type of fall, until falling is reduced, stopped or until the reason for the continuation of falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each residents response to the intervention intended to reduce the risk of falling . When a fall occurs: when a resident has fallen, or is found on the floor, nursing staff will provide comfort, but not move the resident until evaluated for injury. The nursing staff will record vital signs (including orthostatic BP) when appropriate. If a bump on the head is suspected or confirmed complete neuro checks and update the provider timely. Nursing should utilize the neuro flow sheet per policy. I a resident is noted to be on a blood thinking medication and sustains a fall there is significant risk of bleeding. This should be reported to the provider in a timely manner. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. If a fracture is suspected, do not move resident, but stay with resident and wait for instructions. From medical provider or emergency medical staff to arrive. Reporting to the state survey agency. All falls with serious injury that are determined to be a result of abuse, neglect, exploitation or misappropriation shall be reported to the state survey agency through the only reporting process immediately but not later than 2 hours after identifying the injury. For all other falls, follow the Abuse and Neglect Allegations decision tree. Avoidable accident -means that an accident occurred because the facility failed to evaluate/analyze the hazards and risks and eliminate them, if possible , or if not possible identify and implement measures to reduce the hazards/risks as much as possible and/or implement interventions including adequate supervision and assistive devices, consistent with a residents need, goals, care plan and current professional stands of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident and/or monitor the effectiveness of the intervention and modify the care plan as necessary in accordance with current professional standards

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The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48037 Based on interview and record review, the facility failed to comprehensively assess, monitor for signs and symptoms of dehydration and implement timely interventions for 1 of 1 residents (R1) reviewed for hydration status. Findings include: R1's Face Sheet dated 8/23/24, identified R1 had diagnoses that included frontal lobe and executive function deficit following cerebral infarction, aphasia following cerebral infarction, fracture of T7-T8, type 2 diabetes mellitus and benign prostatic hyperplasia without lower urinary tract symptoms. R1's Admission data collection dated 8/23/24, identified R1's nutritional status identified weight loss/gain in the last month and mechanically altered diet. R1 used a foley catheter. R1's care plan dated 8/23/24, identified a focus of nutritional status with the goal to maintain adequate nutritional status. R1 was to have diet regular diet, mechanical soft texture, and nectar consistency. Care plan was updated on 8/26/24 as R1 required assist with feeding. R1's orders dated 8/23/24, identified R1 required staff to obtain output every shift. Staff are to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, nose bleeds. R1's record did not include a comprehensive nutritional assessment that identified daily caloric and fluid needs and goals. R1's fluid intake and output logs were reviewed from 8/23/24 through 8/28/24. R1's record did not include an evaluation of 24-hour daily intake to ensure adequate hydration. R1's Fluid record log included the following documentation: o 8/24/24 at 9:49a.m. 120cc's (cubic centimeters), and at 1:22 p.m. 355cc's o 8/25/24 at 11:39a.m. 120 cc's, at 1:36 p.m. resident refused, at 8:19 p.m. 150 cc's o 8/26/24 at 10:37 a.m. resident refused, at 1:58 p.m. resident refused, at 8:59 p.m. 150 cc's o 8/27/24 at 12:00 noon 480 cc's, at 12:17 p.m. 480cc's, at 7:44 p.m. 240 cc's o 8/28/24 - Resident not available R1's output log included the following documentation: o 8/23/24 nocturnal shift (Noc) 650 cc's o 8/24/24 Day 850 cc's, Evening1,000 cc's, Noc 500 cc's (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o 8/25/24 Day 700 cc's, Evening 350 cc's, Noc 300 cc's o 8/26/24 Day 500 cc's, Evening 250 cc's, Noc 250 cc's o 8/27/24 Day 250 cc's, Evening 350 cc's, Noc 300 cc's o 8/28/24 hospitalized During interview on 9/6/24 at 10:18 a.m., registered Dietitian-(A) stated typically residents who are short term rehab, without specifically calculating, calculating it would say a rough estimate of 1,500 ml intake a day and food at least 50%. D-A explained based off chart review R1 had poor oral intake and could have benefited from a supplemental source of hydration. He would have been at risk for dehydration because he had Covid and had pressure ulcers. There was a tool to screen for malnutrition however R1 had not been at the facility so one was not completed, and a comprehensive assessment was not completed. The facility had not notified her of any concerns or was a part of his care. R1's record did not include and was not evident R1 was continuously assessed and monitored for signs and symptoms of dehydration for any necessary treatments or interventions even though R1 was at risk for dehydration. R1's progress note dated on 8/23/24 and 8/24/24, indicated R1 was alert and orientated only to himself. R1 had an indwelling urinary catheter (Foley) that was draining clear yellow urine. The note indicated R1 ate meals and drinks fluids by mouth, he had adequate food/fluid intakes this shift. Fluids were encouraged. R1's progress note dated on 8/25/24 at 1:56 p.m. R1 was disoriented to person place and time. Urine color as clear yellow. R1's progress note dated on 8/25/24 at 7:55 p.m., identified R1 was alert and oriented to person. 240 cc of fluid this shift, few bites of his meal. R1 was febrile with a temperature of 101.4 (normal ?). Tylenol was administered and effective. R1's progress note dated on 8/26/24 at 7:55 p.m., indicated R1 was alert and oriented and urine color was clear yellow. Adequate food/fluid intake this shift. Holding food in mouth/cheeks or residual food in mouth after meals. Encouraged fluid intake. R1 was more alert and offered few words but responding to yes/no questions. R1 had 240 cc of fluid for this shift, few bites of meals. R1's progress note dated on 8/26/24 at 1:18 a.m., identified. R1 had 120 cc nectar apple juice. At 10:17 a.m. no swallowing difficulties observed, encouraged increase fluid intake, and R1 displayed difficulty of movement in extremities. R1's progress note dated on 8/27/24 at 3:59 p.m. R1 ate 100% breakfast and 50% lunch with fluid intake. Clear amber urine and fluids were encouraged this shift. R1's history and physical by nurse practitioner dated 08/27/24, Identified since admission R1 was minimally responsive, will occasionally answer yes/no questions, R1 had not been out of bed and had poor intake by mouth. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated on at 8/28/24 12:28 p.m., Urine was amber color. Fluids encouraged this shift. Displays a decreased appetite this shift. Decreased fluid intake this shift. R1's progress note dated on 8/28/24 at 11:36 a.m., Order received to send R1 to hospital for altered mental status and multiple falls Resident urine appears to be dark in color compared to baseline. R1's current diet was nectar consistency (resident doesn't like the consistency currently working with speech therapy). R1's Emergency Medical Services (EMS) records identified being notified on 8/28/24, at 10:52 a.m. due to a fall and altered mental status. Facility staff reported to EMS R1 had an altered baseline, but on this day, it was worse and R1 was not using complete sentences like usual. Staff reported R1 was on thickened liquids and not receiving enough water and R1 was dehydrated. Fluid bolus administered and as a result did increase responsiveness. R1 was receiving 550 milliliters (ml) of normal saline. R1's blood pressure at 11:20 a.m. was 98/65 pulse was 113 regular, respirations at 30 with rapid effort. During a follow up return call from 09/06/24 at 1:27 p.m., emergency medical technician (EMT)- A reported to be present and part of the transport assist to the hospital. On arrival R1 was noted to be found sitting alone in a wheelchair in his room with his head down and his fluids were across the room on a table out of his reach. Upon physical observation R1 appeared extremely dehydrated and was difficult to arouse. R1 had thick build up on his lips, his tongue was dry/discolored, his mouth had a heavy layer of thickened matter on it and EMT-A was concerned R1 was dehydrated. EMT-A had asked the facility staff the last known time R1 had fluids and they were unable to answer. EMT-A explained oxygen and intravenous fluid (IV) fluids were immediately initiated and R1 started to perk up and engage more after he got some fluids. R1's emergency department visit note dated 8/28/24 at 3:18 p.m. indicated R1 arrived to the hospital at 12:01 p.m. R1 was ill appearing and mouth mucous membranes were dry. Abnormal urinalysis and evidence of dehydration. Sodium level was 150 compared to last taken on 8/23/24 when it was 138, creatine now 1.97 compared to 1.05 on 8/23/24. During interview on 9/4/24 at 11:28 a.m., nursing assistant (NA)- A indicated familiarity with R1. R1 was Covid positive and had to eat in his room, required staff assistance, and did not eat a lot. There were a lot of times when she delivered a food tray to his room and he would be sleeping so she would re-attempt. R1 would maybe eat 25% and drink a cup a day during NA-A'S shift for breakfast and lunch. NA-A recalled R1's urine was usually darker in color and R1 had loose stools and diarrhea frequently. During interview on 9/5/24 at 2:30 p.m., NA-B recalled R1 typically ate about 25% of his food and would help him drink his fluids. He would typically drink about 160 cc's of fluid for breakfast and would drink more than he ate. R1 frequently had diarrhea and his urine was darker in color. During interview on 9/5/24 at 12:26 p.m., NA-C worked the night shift and R1 was not ever hungry or thirsty. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 9/6/24 at 9:41 a.m., registered nurse (RN)-C stated when residents were on thickened liquids they were at risk for dehydration. When a resident was at risk for dehydration the facility would implement a standing order to monitor for signs and symptoms for dehydration such as confusion, lethargy, tenting of skin or delayed rebound, and dry oral mucosa. The monitoring would be documented on the treatment administration record (TAR). RN-C reviewed R1's record and reported on 8/25/24 an order was put to monitor output however, there was not an order to monitor for dehydration and 24 hour-intake was not calculated. During interview on 9/5/24 at 1:54 p.m., RN-A worked with R1 multiple times. Staff would attempt to assist R1 with eating and drinking but he would not drink a lot. RN-A thought R1 was dehydrated. During interview on 9/5/24 at 12:38 p.m. nurse manager (NM)-A reported residents who were identified at risk of dehydration should see a dietician to lower risks of becoming dehydrated so the nutritionist can assess the fluid needs of the resident. NA-A was not aware if R1 had been seen by the dietician. During interview on 9/5/24 at 2:53 p.m., culinary director (CD)-A recalled R1 required a room tray due to isolation precautions and was on a mechanical soft nectar thick diet (fluids had been altered to a thicker consistency). CD-A recalled R1 was not really eating or drinking. He would be offered water, juice or milk with all of his meals and would eat and drink about half of what was served. CD-A was involved in general conversations with R1 not drinking enough, but figured R1 was not feeling well because of Covid. CD-A could not recall if R1 was in the facility long enough to meet the dietitian. During interview on 9/6/24 at 12:58 p.m., nurse practitioner (NP)-A reported R1 was at risk of dehydration and was notified by facility staff R1 was not drinking very much fluid. Staff were expected to manage the fluid intake by encouraging fluid consumption and document the results. NP-A would expect ideally a resident in that situation would have had a dietician consult. Policy titled hydration dated 09/2012, identified aging is one of the major factors for dehydration resulting from physiological changes in kidney functions, changes in thirst mechanism, ad chronic diseases impairing the elderly's functional abilities. Dehydration in the elderly has long been considered a significant health problem which can lead to increased morbidity and mortality and costly medical care. It is the policy to provide adequate hydration to each resident so that each one is able to achieve and maintain overall health status. The facility will provide adequate hydration by taking into consideration each residents underlying disease state, mental and physical limitations; unless the residents clinical condition indicates that a decline is unavoidable. 1. Upon admission the hospitality services director and/or dietitian will assess each resident for a minimum fluid needs. 2. Hydration status will be assessed upon admission by the nurse manager or other designated nurse and documented on the initial nursing assessment form. 3. A resident's actual fluid requirement will be jointly determined by the Hospitality service doctor and/or Dietitian and Nurse Manager and/or Director of Nursing, and documented on the Nutrition Assessment Form. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Resident with significant increase in respiratory rates for prolonged periods of time. j. Residents with wounds that have large volumes of drainage. k. Resident with determined at nutritional risk, l. Resident with meal intake less than 50%. Fluid intake will be monitored for the resident per nurse manager and/or hospitality service directors discretion. If it is determined their condition is compromised due to inadequate fluid intake, their individual fluid requirements will be documented in the care plan