STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson Memorial Hosp & Home	1290 Locust Street Dawson, MN 56232

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47497 Based on interview and document review, the facility failed to notify the county (designated state mental health authority (SMHA)) when 1 of 1 resident (R2) had new on-set of mental illness since admission. R2's 2/22/24, annual Minimum Data Set (MDS) assessment identified R2 had diagnosis of delusional disorders, paranoid schizophrenia, obsessive-compulsive disorder, depression, and anxiety. R2's 8/16/10, pre-admission screen (PAS) identified R2 did not have a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition. R2's undated, current diagnosis list identified R2 received a new diagnosis of schizophrenia on 10/15/15, obsessive-compulsive disorder on 10/15/15, and a new delusional disorder on 2/29/24. R2's medical record lacked any indication that the county (SMHA) had been notified since the new-onset of R2's mental illnesses. Interview on 4/9/24 at 9:48 a.m., with the social service designee identified he reviews the PAS upon admission but there is no process in place to ensure he is notified if a resident receives a new diagnosis of mental illness. Interview on 4/10/24 at 10:11 a.m., with the administrator identified that she would expect the facility to notify the SMHA authority when a resident receives a new qualifying mental illness diagnosis. She identified the facility process was to discuss new diagnosis at their daily meeting so the social service designee should have been aware of R2's new onset diagnosis. Review of the facility Pre-Admission Screening policy identified the social worker or director of nursing was responsible to contact Senior Linkage when a resident requires a referral for a new PASARR due to a new on-set diagnosis of mental illness.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 1 resident (R20) with peripheral edema and diagnosis of cardiomyopathy (disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body). Findings include: R20 was admitted [DATE], with diagnoses of diabetes, implantable cardiac defibrillator, and hypertensive heart disease (disease cause by high blood pressure affecting the heart). R20's 3/29/24 psychosocial note identified she had attended her care conference and nursing had discussed her leg edema with suggestions for management. R20 voiced agreement to try some interventions. R20's 3/21/24 dietary progress note identified her weight had increased 11.2% in the past 30 days. It was noted that some of the increased weight could be related to fluid retention, but it was suspected she was non compliant with her diet restrictions and her feet and ankles were edematous. R20's 3/12/24, nurse practioner (NP) identified she had been contacted on 3/11/24 by nursing staff with concerns regarding R20's lower extremity edema and a 10 pound (lb) weight gain. Treatment was ordered for Lasix 20 milligrams (mg) by mouth (PO) daily (QD) for 3 days. R20's 3/15/24 annual Minimium Data Set (MDS) assessment identified her cognition was intact, and she was independent with activities of daily living (ADL). R20's undated, current care plan identified she suffered from cardiomyopathy, diabetes, heart disease and had an automatic implanted cardioverter-defibrillator ((AICD) electronic device surgically placed in the chest to monitor and correct abnormal heart rhythms). Staff were to monitor vital signs weekly and as needed (PRN). The physician (MD) was to be notified of significant abnormalities and directed to monitor/document/report signs/symptoms of altered cardiac output or ACID malfunction which included dizziness, syncope (brief loss of consciousness), difficulty breathing, pulse below programmed rate and lower than baseline blood pressure. The careplan failed to include any mention or interventions for edema which was also a side effect of heart failure. Observations of R20 from 4/8/24 through 4/10/24 identified she was observed either seated in either her wheelchair or cushioned chair in her room, with her bare feet on the floor. R20's bilateral feet and ankles had 4 + edema and were reddish in color. The only time R20 was observed to have her legs elevated was when she was sleeping in bed and there was not any stockings or wraps noted on her feet or legs. Interview on 4/09/24 at 2:00 p.m. with nursing assistant (NA)-B reported R20 sat with her feet resting on the floor most of the time, and did not wear any support stockings. She reported both her feet and ankles were usually really swollen. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/09/24 at 4:32 p.m., with NA-C identified R20 spent most of her time when awake sitting in either her wheel chair of cushioned chair with her feet resting on the floor. She reported she had a foot stool but she was not aware of her using it, and she did not wear any compression stockings or have her legs wrapped that she was aware of. Interview on 4/10/24 at 7:15 a.m. with licensed practical nurse (LPN)-A reviewed R20's medication administration record (MAR) and confirmed R20 was not receiving a diuretic currently. Interview on 4/10/24 at 7:13 a.m. with the director of nursing (DON) reported R20 had been encouraged to elevate her legs, has had medication review with changes and attempts to provide education about her edema, but she refused to wear compression stockings, and was insistent on sitting with her feet on the floor. She reported she had a foot stool by her chair but refused to use it because she was afraid of falling. The DON reported the MD and NP were aware of the foot and ankle edema which she identified as 4+ and had attempted interventions, but she continued to be non-complaint. The DON confirmed the care plan did not address the problem of peripheral edema, a side effect of cardiomyopathy and should be up dated to include edema with interventions for monitoring of edema and weight changes. Review of the April 2023, Comprehensive Person-Directed Care Plan and Baseline Care Plan policy identified the care plan was to be individualized and comprehensive to ensure continuity of care. The care plan was to be reviewed every month (30 days) on each shift by both a licensed nurse and NA. Any revisions were to be shared with the MDS nurse to allow for revision to the MDS. Revisions of both the care plan and MDS were to be completed with a condition change or revised to address current problems.