

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Norris Square		STREET ADDRESS, CITY, STATE, ZIP CODE 6993 80th Street South Cottage Grove, MN 55016	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584</b></p> <p>Based on observation, interview, and document review, the facility failed to clean and maintain a resident's wheelchair for 1 of 1 resident (R4) reviewed for safe, clean, and homelike environment.</p> <p>Findings include:</p> <p>R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was cognitively intact, was dependent on staff for mobility in a manual wheelchair, required partial/moderate assistance with transfers and set up/clean up assistance with meals. The MDS indicated R4 would have a loss of liquids/solids from mouth when eating or drinking. R4's diagnoses included progressive supranuclear ophthalmoplegia (a condition affecting the movement of the eyes), dysphagia (a condition affecting one's speech), and anxiety.</p> <p>R4's care plan dated 9/6/24, indicated R4 had an activities of daily living (ADL) self-care performance deficit and instructed staff to assist as needed with dressing, grooming, eating, bathing, and mobility. The care plan instructed staff to place a clothing protector on shirt and lap during meals.</p> <p>R4's clinical nutrition assessment dated [DATE], indicated R4 required an extra clothing protector for lap protection from spills and that R4 had a loss of food/liquids from mouth.</p> <p>R4's nursing assistant care sheet (south unit) dated 10/22/24, indicated R4's bath day was Monday mornings and laundry was pulled from R4's room on Sunday evenings.</p> <p>The south unit laundry/wheelchair cleaning schedule dated 6/13/24, indicated R4's room number was listed on Sunday (wash sling) and Wednesday.</p> <p>During observation and interview on 10/21/24 at 2:24 p.m., R4's right side of her wheelchair seat and seat cushion had dried liquids, cereal ,and other unidentified dried food items. R4 stated did not like the chair being dirty and did not know last time it had been cleaned.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 10/22/24 at 1:18 p.m., nursing assistant (NA)-A confirmed R4's wheelchair was very dirty with dried cereal and other food items on and under the right side of the seat cushion. NA-A stated that there was a schedule for wheelchair cleaning and the overnight staff cleaned them per the schedule, however it was the responsibility of all staff to ensure the resident's wheelchairs were clean. NA-A stated that if a dirty wheelchair was identified by staff, that staff should clean it or ensure it was cleaned right away.</p> <p>During observation on 10/23/24 at 1:00 p.m., R4 was in the dining room eating lunch in her wheelchair. The right corner of the seat appeared dirty with dried food items.</p> <p>During observation on 10/23/24 at 1:58 p.m., R4's wheelchair was still extremely dirty with the same dried liquids, cereal, and other unidentified food items.</p> <p>During interview on 10/23/24 at 2:06 p.m., registered nurse (RN)-A stated wheelchairs were cleaned weekly on the resident's bath day per the schedule but should be cleaned on an as needed basis as well. RN-A stated staff were expected to clean the wheelchairs immediately when identified as dirty, and should not just wait for the weekly scheduled washing. RN-A stated R4's wheelchair could get pretty dirty during meals due to the way she ate and leaned to the right side.</p> <p>During interview on 10/23/24 at 2:10 p.m., director of nursing (DON) stated wheelchairs were scheduled to be cleaned weekly on the resident's bath day, but the expectation was for staff to maintain a clean wheelchair throughout the week. DON further stated R4's wheelchair could get pretty dirty during meals and should probably be on a twice a week schedule for cleaning.</p> <p>Facility policy Infection Control Wheelchair Cleaning dated October 2015, indicated, Wheelchairs will be maintained in a clean, hygienic condition.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was administered as ordered and maintained appropriately for 1 of 1 resident (R16) reviewed for respiratory services.</p> <p>Findings include:</p> <p>R16's admission Minimum Data Set (MDS) dated [DATE], indicated R16 had moderately impaired cognition and required assistance with many activities of daily living (ADLs). The MDS indicated R16 required oxygen therapy and had diagnoses including respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), dementia, and anxiety.</p> <p>R16's care plan dated 9/19/24, indicated R4 had an alteration in respiratory status related to COPD, respiratory failure, and CHF and required the use of oxygen. The care plan instructed staff to ensure R16 had a full portable oxygen tank prior to leaving his room for meals and activities and to ensure oxygen was delivered via nasal cannula as ordered.</p> <p>R16's provider order dated 10/16/24 indicated, oxygen 4lits [liters] continuous. Can increase to 6lits [liters] PRN [as needed] to keep sats [blood oxygen saturation level] above 90%.</p> <p>R16's October 2024 treatment administration record (TAR) indicated, Fill and check portable liquid and O2 [oxygen] tank supply sufficiency every shift and as frequently as needed depending on liter flow rate .Tubing and canula in plastic bag and hang appropriately when not in use.</p> <p>R16's care sheet dated 10/22/24, instructed staff to Fill portable O2 tank before leaving room for meals and to help with O2 tubing.</p> <p>During observation and interview on 10/21/24 at 2:38 p.m., R16 was in his room sitting in the recliner but still receiving oxygen via nasal cannula through the portable tank hanging on the back of his wheelchair. The level of O2 in the portable tank was on the lowest edge of green indicating very low or almost empty. R16's oxygen concentrator was off and sitting next to the recliner. The tubing connected to the concentrator was undated and laying on the floor between the recliner and the bathroom. R16 stated he did not know when the staff last checked or filled the portable tank or changed the O2 tubing.</p> <p>During observation on 10/22/24 at 9:49 a.m., R16 was sitting in common area with several other residents waiting for an exercise activity to begin. R16 had O2 on through nasal cannula connected to a portable tank. The level in the tank was again at the lowest limit of the green indicator, appearing very low.</p> <p>During observation on 10/22/24 at 11:56 a.m., R16 was in his room sitting in the recliner. He was receiving oxygen via nasal cannula connected to the portable tank hanging on his wheelchair. The O2 level indicator now in the red indicating the tank was almost empty or empty. The concentrator was next to him, turned off and tubing lying on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 10/22/24 at 12:04 p.m., R16 self-propelled out into the hallway. Nursing assistant (NA)-A walked by and told R16 he would assist him to lunch in a minute and would fix his oxygen. At 12:06 p.m., NA-A adjusted R16's nasal cannula and wheeled R16 to the dining room. NA-A did not check the level of oxygen in the portable O2 tank.</p> <p>During observation on 10/22/24 at 12:59 p.m., licensed practical nurse (LPN)-A pushed R16's wheelchair out of the dining room into the hallway and encouraged R16 to self-propel back to his room. LPN-A did not check the portable tank. Director of nursing (DON) approached R16 and offered to assist him back to his room. R16 declined. DON did not check R16's portable tank. R16 self-propelled approximately 60 feet to his room.</p> <p>During observation and interview on 10/22/24 at 1:38 p.m., unidentified hospice music therapist left R16's room after 30 minutes of music therapy. R16 was sitting in his room in his wheelchair and was not wearing his nasal cannula which was hanging off the arm of the wheelchair. R16 stated he thought the tank was empty and checked the nasal cannula confirming no O2 flow. R16 stated he could not remember the last time staff checked or filled the portable tank.</p> <p>During observation on 10/22/24 at 1:45 p.m., R16 was standing in the hallway inquiring about the upcoming activities. NA-B identified R16 standing unassisted and escorted him back into his room and into his wheelchair. NA-B asked if R16 needed anything from her, he declined, and she left the room. NA-B did not address R16's oxygen and did not place R16 back on the nasal cannula.</p> <p>During observation and interview on 10/22/24 at 1:50 p.m., LPN-A stated nurses were responsible for oxygen therapy maintenance. LPN-A stated her practice was to round at the start of the shift to ensure O2 was on as ordered and tubing was maintained appropriately. LPN-A further stated portable tanks were supposed to be checked by any staff prior to placing a resident on the tank and prior to leaving the room. LPN-A entered R16's room and identified R16 without his nasal cannula in place. LPN-A immediately placed R16 on O2 via the concentrator. LPN-A stated R16 should be on his concentrator when in his room and that all staff were responsible for ensuring he was wearing the nasal cannula and on the concentrator when in his room. LPN-A confirmed the portable tank was empty and also that the concentrator tubing should not be lying on the floor. LPN-A replaced the portable tank with a full one, refilled the water on the concentrator humidifier, and replaced the concentrator tubing with new tubing.</p> <p>During interview on 10/23/24 at 8:15 a.m., registered nurse (RN)-A stated staff should always check the portable O2 tanks when the resident was placed on the tank and each time prior to leaving the room. RN-A stated the resident should be on the concentrator when they were in their room rather than the portable to conserve the oxygen in the portable tank. RN-A stated R16 was on 4 liters of O2 and could go through a portable tank pretty quickly and checking his tank prior to leaving the room was very important. RN-A further stated O2 tubing should not be lying on the floor when not in use.</p> <p>During interview on 10/23/24 at 12:01 p.m., DON stated it was the nurse's responsibility to ensure oxygen therapy was maintained per provider orders. DON stated residents should be on the O2 concentrator when in their room and that the portable tank should be checked and full when the resident leaves their room and the expectation for any staff to check the portable tank prior to the resident leaving his room. DON further stated O2 tubing should not be lying on the floor when not in use for infection control.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility policy Oxygen Administration dated February 2017, indicated nurses should check each shift, or more frequently as appropriate, the O2 tank to ensure appropriate flow and sufficient O2 is present in tank. The policy further indicated, Tubing, humidifier and nasal cannula, mask or other apparatuses to administer oxygen should be placed in a plastic bag when not in use.</p> <p>Facility policy Oxygen Equipment Care and Maintenance dated October 2011, indicated, Tubing is not to touch the floor .Curl tubing and place, with mask/cannula, in a plastic bag and hang appropriately .On each shift the nurse should monitor liter flow of oxygen.</p>		