DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X11C

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROOKVIEW A VILLA CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/15/17** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **144** (L18)
13.Total Certified Beds **144** (L17)

10.THE FACILITY IS CERTIFIED AS:
**X** A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 144 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 11/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 02/17/2018 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
**08/31/1973**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**06301**
(L31)

30. REMARKS
Posted 03/07/2018 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**11/06/2017**
(L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN: 24-5186

Due to previous noncompliance for abbreviated standard surveys completed June 15, 2017 and July 10, 2017, this Department imposed
• State Monitoring effective August 2, 2017. (42 CFR 488.422)

In addition, MDH recommended and CMS concurred with the imposition of :
• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417 (b))

On October 4, an abbreviated standard survey was completed and the most serious deficiencies were cited at a S/S of G at F309.

On October 5, 2017, an extended survey was completed and the most serious deficiencies were cited at a S/S of J at F309 and F373. This is a no opportunity to correct (NOTC), and this Department previously imposed the Category 1 remedy of State monitoring, effective August 2, 2017.

We also recommended the following enforcement action to the CMS RO for imposition:

- CMP for the deficiency cited at F373.
- CMP for the deficiency cited at F309.

The abbreviated standard and the extended survey both cited F309, for different patients, for differing reasons.

On November 15, 2017, Post Certification Revisits (PCRs) were completed by this Department and the Office of Health Facility Complaints, verifying that all health deficiencies have been corrected. Therefore, MDH discontinued State Monitoring as of November 15, 2017. Additionally, as a result of the revisit findings, MDH recommended the following actions to the CMS RO and CMS RO concurred:

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective October 13, 2017 be rescinded
- CMP for the deficiency cited at F373 remain in effect.
- CMP for the deficiency cited at F309 remain in effect.

Due to imposition of Mandatory DPNA, the facility also incurred two years of NATCEP loss.

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245186

November 22, 2017

Ms. Catherine Scoville, Administrator
Golden Valley Rehabilitation and Care Center
7505 Country Club Drive
Golden Valley, MN 55427

Dear Ms. Scoville:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 13, 2017 the above facility is certified for:

144 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 144 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered

November 22, 2017

Ms. Catherine Scoville, Administrator
Golden Valley Rehabilitation and Care Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Numbers: S5186032, H5186226, H5186228, H5186233
H5186240, H5186243 and H5186247

Dear Ms. Scoville:

On July 28, 2017 and October 18, 2017, as authorized by the CMS Region V Office, we informed you that the following enforcement remedies were being imposed:

• State Monitoring effective August 2, 2017. (42 CFR 488.422)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letters of July 28, 2017 and October 18, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 15, 2017.

This was based on the deficiencies cited by this Department's Office of Health Facility Complaints for an abbreviated standard survey completed on June 15, 2017, an abbreviated standard survey completed on July 10, 2017 and lack of verification of compliance with deficiencies issued pursuant to the June 15, 2017 and July 10, 2017 abbreviated standard surveys, at the time of our July 28, 2017 notice. The most serious deficiency was found to be a widespread deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 4, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid Programs. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On October 5, 2017, an extended survey was completed at your facility by the Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid programs. The facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health and safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby significant corrections were required.

As a result of finding that your facility continued to not be in substantial compliance we notified you that the Category 1 remedy of State monitoring would remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of July 28, 2017 and October 18, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017, would remain in effect. (42 CFR 488.417 (b))

- Civil Money Penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil Money Penalty for the deficiency cited at F373, be imposed. (42 CFR 488.430 through 488.444)

On November 15, 2017, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification Program completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on June 15, 2017, an abbreviated standard survey completed on July 10, 2017, an abbreviated standard survey completed on October 4, 2017, and an extended survey completed October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 13, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard surveys of June 15, 2017, July 10, 2017 and October 4, 2017 and our extended survey completed on October 5, 2017, effective November 13, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective November 13, 2017.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letters of July 28, 2017 and October 18, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of the action:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017, be discontinued effective November 13, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 15, 2017, is to be discontinued, effective November 13, 2017. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 15, 2017, is to be discontinued, effective November 13, 2017.

Further, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 18, 2017:

- Civil Money Penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil Money Penalty for the deficiency cited at F373, be imposed. (42 CFR 488.430 through 488.444

The CMS Region V Office will notify you of their determination regarding the recommended remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File
Office of Health Facility Complaints File

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On November 14, 2017,

I, Robert Britain, Director of Operations, received
(Name)(Please Print) (Title)(Please Print) Fortis Management,
the Notice of Penalty Assessment dated and licensing orders issued to:

Golden Valley Rehabilitation and Care Center
7505 Country Club Drive
Golden Valley, MN 55427

The Penalty Assessments and licensing orders attached hereto have been corrected as of .

Signed: [signature], Director of Operations, Date 11-14-17
(Name)(Please Print) (Title)(Please Print) Fortis Management

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On November 14, 2017,

I, Jennifer Baur, HFE Nursing Eval II, of the Division of
(Name)(Please Print) (Title)(Please Print)
Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:

Golden Valley Rehabilitation and Care Center
7505 Country Club Drive
Golden Valley, MN 55427

The Notice of Penalty Assessment was handed to Robert Britain,
(Name)(Please Print)
Director of Operations Date 11-14-17
(Title)(Please Print) Fortis

Signed: [signature], HFE Nursing Eval II, Date 11-14-17
(Name)(Please Print) (Title)(Please Print)

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X11C

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2. STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN VALLEY REHABILITATION AND CARE CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **10/05/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **144** (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory DOPNA is effective 09/15/2017.

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 10/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/06/2017 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
**08/31/1973**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**06301**
(L31)

30. REMARKS

Posted 11/06/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS
FOR NURSING HOMES

Hand Delivered on October 25, 2017.

October 25, 2017

Ms. Kayla Bleskacek, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, MN 55427

Re: Project # O468, 6DS5, X11C1

Dear Ms. Bleskacek:

On October 5, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a survey of your facility for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10.

If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

State licensing orders issued pursuant to the previous abbreviated standard survey completed on July 10, 2017, found not corrected at the time of this October 5, 2017 revisit and subject to penalty assessment are as follows:

| | | |
|---|---|---|
| S0565 | Comprehensive Plan of Care; Use | $300.00 |
| S0800 | Nursing Personnel; Staffing Requirements | $300.00 |
| S1665 | Physical Environment | $200.00 |
| S1855 | Patients & Residents Of Hc Fac.Bill Of Rights | $250.00 |

State licensing orders issued pursuant to the previous abbreviated standard survey completed on October 4, 2017, found not corrected at the time of this October 5, 2017 revisit and subject to penalty assessment are as follows:

| | | |
|---|---|---|
| S0830 | Adequate And Proper Nursing Care; General | $350.00 |

The details of the violations noted at the time of this revisit completed on October 5, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1400.00 per day beginning on the day you receive this notice.

**The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 3333 W Division, #212 St Cloud Mn 56301.**

**When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.**

**If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.**

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992     Fax: (651) 215-9697

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Submitted
October 18, 2017

Ms. Kayla Bleskacek, Administrator
Golden Valley Rehabilitation And Care Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Numbers S5186032, H5186226, H5186228, H5186233, H5186240, H5186243, and H5186247

Dear Ms. Bleskacek:

On July 28, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 2, 2017. (42 CFR 488.422)

On July 28, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS) Region IV Office, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417 (b))

Also we notified you in our letter of July 28, 2017 in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 15, 2017.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on June 15, 2017, and continuing noncompliance at the time of the abbreviated standard survey completed on July 10, 2017. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 4, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. Based on our visit, we have determined that your facility's non-compliance continues. The most serious deficiencies were found to be **isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G)** whereby corrections were required.

On October 5, 2017, an extended survey was completed at your facility by the Minnesota Department of Health and on October 13, 2017, a survey was completed by the Minnesota Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;
>
> Appeal Rights - the facility rights to appeal imposed remedies;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and
>
> Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

## REMOVAL OF IMMEDIATE JEOPARDY

We also verified on October 5, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the **extended** survey resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

Questions regarding this letter and all documents submitted as a response to the **abbreviated standard survey, complaint investigation** resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

## NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following

circumstances exist:

• Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
• Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
• Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
• Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR d eficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
• A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. On July 28, 2017, we informed you that the following enforcement remedies were imposed:

• State Monitoring effective August 2, 2017. (42 CFR 488.422)
• Mandatory Denial of Payment for new Medicare and Medicaid admissions effective September 15, 2017. (42 CFR 488.417(b))

In addition, as a result of the continued non-compliance identified at the time of the October 4, 2017 abbreviated standard survey and the October 5, 2017, extended survey the Department recommended the enforcement remedies listed below to the CMS Region IV Office for imposition:

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F373. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have

received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Valley Rehabilitation and Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 15, 2017. This prohibition is not subject to appeal. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and

conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245186 | A. BUILDING ______ B. WING ______ | 10/05/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN VALLEY REHABILITATION AND CARE CENTER | 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 10/1/17 to 10/5/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Golden Valley Rehab and Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F309 and F373 when a resident was observed to have on-going issues with coughing while eating. Staff were not following the feeding program established by the speech language pathologist due to dysphagia (difficulty swallowing). The facility was notified of the IJ on 10/4/17, at 4:15 p.m. and was removed on 10/5/17, at 2:54 p.m. when the facility implemented a removal plan which included educating dietary, speech therapy, and nursing staff identified whom could and could not feed residents, a nurse was required to be present in the dining room when residents were eating, and location of individual resident swallowing guidelines and specific feeding program to follow for R19.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/26/2017

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.

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| F 000 | Continued From page 1<br>regulations has been attained in accordance with your verification. | F 000 | | |
| F 157<br>SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the | F 157 | | 11/13/17 |

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| F 157 | Continued From page 2<br>resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the resident's representative was notified timely of medication changes, updates on condition and treatment requiring injection of medication for 1 of 1 resident (R16) reviewed for notification of change.<br><br>Findings include:<br><br>R16's quarterly Minimum Data Set (MDS) completed on 7/13/17, identified moderate cognitive impairment and moderate depression.<br><br>R16's Admission Record dated 5/1/17, identified family member (FM)-A as Emergency Contact #1, Responsible Party, and POA-Financial, with a hand written, undated entry identifying "legal guardian."<br><br>During interview on 10/2/17, at 3:51 p.m. FM-A stated the facility had called when a recent fall occurred, but notification had not been made related to medication changes or new orders. FM-A added R16 has had medication changes | F 157 | R-16 has had notification of medication changes made to resident and/or responsible party.<br>Residents with new medication orders will have documented notification of resident and/or responsible party. Visual cue has been added to resident's medical record for those residents with a guardian and those identified by social service of family requesting updates.<br>LN staff have been re-educated on the notification of change policy and procedure to include medication changes.<br>Nursing Management will audit telephone orders M-F and resident records for documentation of changes of medications and resident/responsible party notification.<br>DON/designee will complete 5 audits of medication changes weekly for 4 weeks then monthly for 2 months for documentation of notification. Audits will be forwarded to the QAPI committee monthly x 3 months for opportunities of continued quality improvement. | |

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| F 157 | Continued From page 3<br>and she had only became aware of it when reviewing the pharmacy statement. FM-A stated she visited routinely and interacted with staff with any concerns either during visit or via a phone call.<br><br>A review of physician's orders of 7/16/17, identified medication changes were made to discontinue Cogentin (a medication used to lessen the side effects of antipsychotic medications) and change to amantadine (a medication used to treat Parkinson's disease). A review of nursing progress notes did not identify order changes made, nor did it identify notification of FM-A of any changes.<br><br>A review of physician's orders noted R16 was on Seroquel 100 milligrams (mg) on 8/22/17, with orders for one tablet every four hours as needed for psychotic behaviors. A review of nursing progress notes did not reflect the new order or notification of FM-A of the new medication.<br><br>A review of the nursing progress note dated 9/3/17, indicated R16 was given a dose of Seroquel which had been ordered on an as needed basis (PRN). Seroquel is an antipsychotic drug which was ordered for psychotic symptoms. FM-A was contacted to inform of R16's mood state and of medication administration. The documentation identified FM-A stated there had been medication changes based on psychiatric recommendations.<br><br>The next narrative note on R16's record was dated 9/15/17, and addressed physician visit for joint injection. The note did not reflect the awareness of FM-A regarding the interventions provided. | F 157 | DON to monitor compliance. | |

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| F 157 | Continued From page 4<br><br>A review of the physician's orders from 9/15/17, identified a joint injection had been given and orders were received for a Lidoderm patch. No nursing progress notes were present to identify new orders or notification of the responsible party of the new medication therapy.<br><br>On 9/25/17, the progress notes identified a change of orders for Percocet (a narcotic pain medication) to increase dosage to twice daily. The record lacked documentation regarding notification of FM-A of change in treatment.<br><br>Upon review of recent medication changes, notification of family regarding new orders was not always documented. During interview on 10/5/17, at 9:52 a.m. the assistant director of nursing (ADON)-B stated this should have been completed when the orders were processed.<br><br>A policy was requested for transcription of physician orders and notification of responsible parties/family members of change in condition or medication orders but was not received. | F 157 | | |
| F 164 SS=D | 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>483.10<br>(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>(h)(3)The resident has a right to secure and confidential personal and medical records. | F 164 | | 11/13/17 |

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| F 164 | Continued From page 5<br><br>(i) The resident has the right to refuse the release of personal and medical records except as provided at<br>§483.70(i)(2) or other applicable federal or state laws.<br><br>§483.70<br>(i) Medical records.<br>(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br><br>(i) To the individual, or their resident representative where permitted by applicable law;<br><br>(ii) Required by Law;<br><br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br><br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide personal privacy for 1 of 6 residents (R121) during observations of personal cares.<br><br>Finding include: | F 164 | R-121 will have privacy maintained during all cares provided as indicated on his/her care plan.<br><br>Residents that reside in the facility have the potential to be affected and will | |

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| F 164 | Continued From page 6<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent upon and required the physical assistance of two staff for bed mobility, eating, dressing, toileting and personal hygiene. The MDS also indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue).<br><br>During observation on 10/3/17, at 11:06 a.m. nursing assistant (NA)-B was in R121's room, and pulled the window drapes shut to begin cares when registered nurse (RN)-B entered the room. RN-B began to gather supplies for a dressing change to R121's wound as NA-D also entered the room, and closed the door behind her. At 11:12 a.m., working on the exit side the bed, NA-D moved R121's gown, pulled down the bed sheet, and untied R121's incontinent brief, rolling the front onto itself, and tucked it between R121's legs. NA-B stood on the opposite side of the bed, while NA-D rolled R121 first toward the exit side of bed to remove the soiled brief, than back to the window side. NA-B held R121 as he faced the wall, while NA-D gathered R121's gown on his stomach, then pulled down the bed sheet, and cleansed R121's bottom with a cloth. Next, NA-D rolled R121 on his back, then cleaned R121's genital area. NA-D left R121's bedside to dispose of the wash cloths and get additional bedding and clothing, while NA-B stood next to R121 in bed, his genitals now fully exposed. At 11:15 a.m., while RN-B finished gathering and setting up supplies for the dressing change, R121 was on his back, his mid body, including genitals, | F 164 | receive personal privacy during personal cares.<br><br>LN and NARs will receive education regarding dignity and privacy needs of residents during care.<br><br>Nurse managers and DON will complete personal care audits to address resident privacy during care on each unit. 3 residents will be audited weekly for 4 weeks then monthly for 2 months. Caring Partners will interview residents weekly on privacy and dignity with cares. Results of interviews will be shared during the facility's meeting structure for corrections if needed.<br><br>Finding of observations and interviews will be forwarded to the QAPI committee monthly for 2 months for opportunities of continued quality improvement.<br><br>DON to monitor compliance. | |

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| F 164 | Continued From page 7 | F 164 | | |

were uncovered and fully exposed; a full minute passed. NA-B remained standing next to R121, and made no attempt to cover R121 while she waited for RN-B. At 11:16 a.m., RN-B started the dressing change, and NA-B rolled and held R121 on his left side, facing the wall as RN-B tended to R121's wound. During the entire treatment, R121's genitals remained exposed, and NA-B made no attempt to provide cover for R121's exposed body areas. At 11:22 a.m., following application of a top dressing, RN-B stepped away from the bed and R121 was rolled on his back, genitals still fully exposed. NA-D and NA-B resumed cares and placed a new brief on R121 at 11:24 a.m., nine minutes after the dressing change began.

For a full minute before, then during, and following R121's dressing change, staff allowed R121's private body area to be exposed, even though a bed sheet, gown, and other towels were accessible to use as a cover.

When interviewed on 10/3/17, at 11:57 a.m. NA-B stated to help guard a resident's privacy staff have to shut the door, pull the curtain, and use a sheet to cover [R121]. NA-B acknowledged that during cares and dressing change, R121 was left uncovered for a long time, was exposed, and stated, "I think I should have covered him up better."

During an interview on 10/4/17, at 9:23 a.m. the assistant director of nursing (ADON) stated residents should be covered to the extent possible during the provision of cares. The ADON stated she considered this "a matter of dignity and privacy" for R121, and for all residents.

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| F 164 | Continued From page 8<br><br>A facility policy, Confidentiality and Privacy, dated July 2015, directed: "Provide resident privacy when receiving treatment and care for personal needs." | F 164 | | |
| F 176 SS=D | 483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess for the safety of self administration of medications for 1 of 1 resident (R48) who was observed to have medications at bedside and also self administered oral medications.<br><br>Findings include:<br><br>R48's quarterly Minimum Data Set dated 6/17/17, indicated R48 was cognitively intact.<br><br>During observation on 10/1/17, at 9:57 a.m. R48 had a bottle of nitroglycerin 0.4 milligrams (mg) on her bedside table.<br><br>R48's Self- Medication Data Collection and Assessment dated 1/10/17, indicated nursing was to administer all medications as the resident was unable to safely self- administer medication.<br><br>R48's physician order dated 7/11/17, indicated it was okay to leave R48's nitroglycerin (medication to treat chest pain) at the bedside. However, | F 176 | R48 has been assessed for ability to self - administer medications.<br>Like residents were identified as self – administering medications have been assessed for ability to perform task independently.<br>LN's have been educated on the need for residents to have a self-medication assessment, physician order, interdisciplinary team review and an individualized self – medication programs in place prior to the initiation of a self-medication program. Medication pass competencies will be completed upon hire and annually to observe for medication practices to include ensuring residents are taking medications as prescribed or documentation reflects differently.<br>DON / designee will audit 5 resident who self – administer medication weekly for 4 weeks then monthly for 2 months to ensure assessments, physician order, care planning and LN nurse knowledge of self – administration programs. Results | 11/13/17 |

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| F 176 | Continued From page 9<br>nursing failed to complete an assessment to ensure R48 was safe to administer the nitroglycerin on her own.<br><br>During observation on 10/1/17, at 10:19 a.m. registered nurse (RN)-E handed R48 her morning medications in a clear cup and left the room. R48 poured the pills onto her bedside table and proceeded to check to make sure what medications were there before self-administrating them. The bottle of nitroglycerin was also noted on the bedside table.<br><br>During interview on 10/3/17, at 10:20 a.m. RN-E stated she did not stay to observe R48 take her medications because it was "alright" to leave them at the bedside and indicated it was because she was a hospice patient.<br><br>On 10/3/17, at 10:22 a.m. RN-A stated medications could be left at a resident's bedside if there was a nursing assessment completed and a physician's order to do so. After reviewing R48's chart, RN-A stated R48 did not have a current assessment indicating R48 was safe to have nitroglycerin at the bedside or for nurses to leave medications for her to self administer after set-up.<br><br>During follow- up interview on 10/3/17, at 10:48 a.m. RN-E stated the medications that had been left at R48's bedside to self administer were: omeprazole (treatment of gastroesophageal reflux disease) 40 mg, ativan (anti-anxiety) 0.5 mg, morphine sulfate (narcotic) 15 mg, two tablets of Tylenol (pain reliever) 500 mg, two capsules of diltiazem (treat high blood pressure, angina and certain heart rhythm disorders) 180 mg, duloxetine (treat major depressive disorder, ) 60 mg, and two capsules of gabapentin (treat | F 176 | will be brought to QAPI committee monthly x 3 months for continued opportunities for quality improvements. DON responsible for compliance | |

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| F 176 | Continued From page 10<br>nerve pain) 400 mg.<br><br>A facility policy on self- administration of medications was requested and was not received. | F 176 | | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure resident's clothing were donned and covered residents exposed skin for 1 of 5 residents (R10). In addition, the facility failed to ensure personal hygiene was maintained in a dignified manner for 2 of 5 residents (R55, R2) reviewed for dignity.<br><br>Findings include:<br><br>R10's Face Sheet indicated diagnoses of CVA (stroke), neuromuscular dysfunction of the bladder, and hemiplegia (weakness) of the left side due to CVA. A quarterly Minimum Data Set (MDS) dated 9/14/17, indicated R10 was cognitively intact, and required extensive assistant of two staff for dressing and grooming.<br><br>During initial tour observations on 10/1/17, at 9:41 a.m. R10 was sitting in the entrance of the facility leaning to the right wearing a soiled smoking apron. The smoking apron hung to R10's right, | F 241 | Resident#55 has been provided with clothing to allow for covering of abdomen when sitting in her wheelchair. Residents #2 and #10 have been provided with / assisted with personal cares to ensure hygiene is maintained in a dignified manner. Resident #2 and #10 have had care plan interventions implemented to provide staff with direction on encouraging resident to allow for personal cares.<br>The facility has assisted residents in need of clothing to promote dignified covering of self with the procurement of needed clothing. Residents identified as needing assistance with ADL's has been provided with cares. Care plans have been reviewed and updated to include interventions to promote resident allowance / participation with ADL's.<br>Staff has been provided with education regarding the donning of clothing to promote dignity and covering of exposed | 11/13/17 |

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| F 241 | Continued From page 11<br>and resident's shirt pulled up exposing his stomach and urostomy (device to collect urine, attached to the abdomen). At 10:03 a.m., R10 was observed to leave the facility to visit with a pastor, sitting outside, stomach and urostomy still exposed.<br><br>On 10/4/17, at 6:51 a.m. R10 was observed again sitting in the facility main entrance. R10 was facing the door. R10 was wearing a red polo shirt which was hiked up to just below his chest, with urostomy fully exposed. R10 stated it bothered him that his stomach and urostomy are exposed, but his clothes are tight. R10 further stated, when transferred from bed to wheel chair (WC) with the lift, the cloth on the WC seat back pulls R10's shirt up as he is lowered into WC. R10 indicated that if his urostomy is tucked into his pants, the bag may rupture or the ostomy wafer will peel off.<br><br>During an interview on 10/4/17, at 12:36 p.m. nursing assistant (NA)-E stated she had assisted R10 this morning and added, "Yes, his belly sticks out. We try to pull shirt down, but it does not always cover his belly."<br><br>A review of the Group 3 nursing assistant care sheet (undated), and R10's care plan (last signed 9/11/17), lacked documentation of instructions to staff to assure R10's clothes covered his stomach and ostomy bag.<br><br>In an interview on 10/4/17, 12:53 p.m. social worker (SS)-A stated that the purchase of new clothing was discussed with family/guardians during R10's quarterly care conference in September. SS-A stated that the facility offered clothes from donations to the facility, however, neither the family/guardians nor R10 wanted R10 | F 241 | skin and appliances, performance of cares to promote cleaning of fingernails, management of incontinence and overall grooming / cleanliness of residents.<br>DON / designee will observe cares on 5 resident per week for 4 weeks then monthly for 2 months to assure cares are provided in a manner to promote dignity during cares and in manner of dress.<br>Results will be brought to QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br>DON to monitor for compliance. | |

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to wear "other peoples" clothes. SS-A stated he was informed the family/guardians would be buying new clothes but was unaware if this had ever occurred. SS-A stated that he would check with laundry services. SS-A stated that floor staff have been educated to adjust R10's clothing when his stomach and ostomy are exposed.

During an interview on 10/4/17, at 12:58 p.m. R10 verified that he was offered donated clothes, but refused. R10 stated his family/guardians were going to be buying him new clothing items.

On the same day, at 1:15 p.m. SS-A stated after checking with laundry, family/guardians had purchased only 2-3 pairs of pants.

In review of a facility policy, entitled: Clothing (effective July 2015), indicated: "1. Coordinate efforts between the resident and / or responsible party to ensure clothing needs are met" AND 2. Assist the resident in the procurement of needed items if requested by the resident."

R55's quarterly MDS dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. Diagnoses included dementia and depression.

On 10/1/17, at 9:50 a.m. R55 was seated in her

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wheelchair in the doorway to her room. A dark brown substance was noted to be under her long fingernails on her right hand.

During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap.

On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.

During interview on 10/4/17, at 8:20 a.m. R55 stated the staff didn't clean her nails and it bothered her and made her feel "dirty."

During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)- A stated residents should not have dirty fingernails and should not be sitting in urine soiled clothing. Further, dirty fingernails and urine soiled clothing which smelled of urine was undignified.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R2 was frequently incontinent of urine, with moisture associated skin damage. Diagnosis included was schizophrenia.

R2's ADL/Mobility care plan, last reviewed on 8/5/17, indicated R2 would be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing

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| F 241 | Continued From page 14<br>and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADLs and at times refused shaving. The care plan lacked approaches to refusal of cares. R2's Urinary Continence care plan, last reviewed 8/4/17, indicated R2 was incontinent and resident refuses to wear incontinent products and occasionally soils self. A behavior indicated R2 would lie in bed and urinate soiling himself and the bed and refused to be changed was noted, however, the care plan did not address how the staff should handle the behavior, other than to encourage him to change his clothing.<br><br>During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweatpants were saturated with urine in the front and back, as well as the right lower side of his shirt. R2 hair was uncombed and sticking up in multiple places. Multiple staff were located around the nursing desk and staff did not offer to take R2 back to his room and assist with changing his clothing or comb his hair. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated with urine. R2's room had a strong odor of urine present that could be smelled in the hallway.<br><br>On 10/3/17, at 10:12 a.m. R2 was walking in the hallway in front of the nursing desk, his shoes were untied, his hair was uncombed and sticking up in multiple places, his gray t-shirt had a tear in the back of the collar from one side of the neck to the other. ADON-A approached R2 and offered to tie his shoes. R2 allowed ADON-A to tie his shoes, however ADON-A did not offer to take him | F 241 | | |

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| F 241 | Continued From page 15 back to his room and help him change his shirt or comb his hair.<br><br>On 10/4/17, at 6:51 a.m. R2 was sitting in the dining room watching television. His hair was uncombed and was sticking up in multiple places. His gray t-shirt had a quarter sized hole in the front. R2 was in the dining room until 9:06 a.m. when he walked down the hall towards his room and laid in bed. Staff did not approach R2 and offer to change his shirt or comb his hair, during this time.<br><br>During interview on 10/4/17, at 8:47 a.m. social services assistant (SS)-A stated R2 had a brother that he had contacted in the past about getting new shoes and the brother bought him a new pair. SS-A stated he had not noticed the holes in R2's clothing and had not notified R2's brother, for help in obtaining new clothing. SS-A stated it was a resident's right to wear what they wanted, however, R2 would never complain about having holes in his clothing unless they were really large.<br><br>During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are aware when R2 was soiled, and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and wasn't sure who did. NA-G stated he was fairly independent but needed hands on assistance frequently and did allow staff to comb his hair and assist with changing his clothes, it just depended on how | F 241 | | |

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| F 241 | Continued From page 16<br>staff approached him.<br><br>During interview on 10/5/17, at 9:39 a.m. ADON-A stated it was unacceptable for a person to walk around in urine soiled clothing. ADON-A added urine odor, soiled clothing , clothes with holes and messy hair were undignified.<br><br>The facility policy Resident Rights dated 7/15, indicated: "The center promotes the resident right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the center. The center must protect and promote the rights of each resident...Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances dignity and respect in full recognition of your individuality." | F 241 | | |
| F 242<br>SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. | F 242 | | 11/13/17 |

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| F 242 | Continued From page 17<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to honor medication time choices for 1 or 4 residents (R48). In addition, the facility failed to honor food choices for 1 of 4 residents (R162) reviewed for choices.<br><br>Findings include:<br><br>R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and included diagnoses of anxiety and depression.<br><br>During interview on 10/1/17, at 3:45 p.m. R48 stated she wanted her evening medications given at 7:00 p.m. but they were scheduled for 8:00 p.m. and sometimes it took a really long time to receive her medications. R48 stated the nurses were aware and was told she had to come ask for them earlier.<br><br>During observation on 10/2/17, at 7:52 p.m. R48 was seated in her wheelchair next to the medication cart waiting for her evening medications.<br><br>R48's Medication Adminsitration Records (MAR) indicated the following:<br><br>October 2017-<br>- gabapentin 400 milligram (mg) 2 capsules by mouth (po) twice daily, scheduled for 8:00 a.m. and 8:00 p.m.<br>- melatonin 3 mg 1 tab po at bedtime, scheduled for 8:00 p.m.<br>-ativan 0.5 mg 2 tabs po at 8:00 pm.<br>- morphine soluble tab 5 mg 2 tabs po at bedtime, scheduled for 9:00 p.m. | F 242 | Resident #48 has had her medication times adjusted to 7:00 pm to accommodate her medication time preference. Resident #162 has an order in place for double portions and is receiving double portioned meals as ordered.<br>Residents requesting medication time adjustments will be reviewed by the interdisciplinary team to ensure requested changes are appropriate and feasible.<br>Residents with orders or preferences for double portioned meals were and are receiving meals as ordered and requested by the resident.<br>LN's have been provided with education regarding the scheduling of medications as requested by the resident within the parameters of physician orders and manufacturer recommendation of administration. Staff has been provided with education regarding the use of diet cards to assure residents are receiving nutrition per physician orders.<br>DON/Designee will audit 5 residents per week for 4 weeks then monthly for 2 months to ensure medications are administered as ordered and per resident preference. Dietary Manager / Designee will audit 5 residents per week for 4 weeks then monthly for 2 months to ensure diets are served as ordered and requested by the resident. Results and follow up to be presented to QAPI committee times 3 months.<br><br>DON will monitor for compliance. | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 242 | Continued From page 18<br>- morphine sulfate ER 15 mg 2 tabs po every evening, scheduled for 8:00 p.m.<br>- MAPAP rapid release gelcap 500 mg 2 tabs po three times daily, scheduled for 8:00 a.m., 12:00 p.m. and 8:00 p.m.<br><br>September 2017-<br>- gabapentin 400 milligram (mg) 2 capsules by mouth (po) twice daily, scheduled for 8:00 a.m. and 8:00 p.m.<br>- melatonin 3 mg 1 tab po at bedtime, scheduled for 8:00 p.m.<br>-ativan 0.5 mg 2 tabs po at 8:00 pm.<br>- morphine soluble tab 5 mg 2 tabs po at bedtime, scheduled for 9:00 p.m.<br>- morphine sulfate ER 15 mg 2 tabs po every evening, scheduled for 8:00 p.m.<br>- MAPAP (acetaminophen) rapid release gelcap 500 mg 2 tabs po three times daily, scheduled for 8:00 a.m., 12:00 p.m. and 8:00 p.m.<br><br>During interview on 10/3/17, at 2:53 p.m. registered nurse (RN)-G stated R48's evening medications were scheduled for 8:00 p.m. and was aware R48 wanted them scheduled for 7:00 p.m.. RN-G stated R48 had been requesting the medication time change for the last one to two months. RN-G stated she was a hospice patient and could not just change the medication times and was not aware if medication time preferences had been communicated to hospice.<br><br>During interview on 10/5/17, at 10:14 a.m. assistant director of nursing (ADON)-A stated she was not aware R48 wanted her evening medications scheduled for 7:00 p.m. rather than 8:00 or 9:00 p.m. ADON-A stated medications scheduled for twice daily or at bedtime could be | F 242 | | |

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| F 242 | Continued From page 19 | F 242 | | |

changed by the nursing staff. The medications that are scheduled for a certain time would need to be communicated to hospice for changes.

The facility policy Resident Rights dated 7/15, indicated: "The center recognizes the resident's right to a quality of life that supports privacy, confidentiality, independent expression, choice, and decision making, consistent with State law and Federal regulation...You have the right to be fully informed in advance about care, treatment, and of any changes in the care or treatment that may affect your well-being and to participate in planning care and treatment or changes in care and treatment, unless you have been adjudged incompetent or found to be incapacitated under state law."

R162's quarterly MDS dated 08/17/17, indicated he was cognitively intact and did not have a poor appetite or over eating. R162's Nutrition Risk Care Plan dated 05/17, indicated he received a regular diet with large portions.

R162's Nutrition Risk Data Collection And Assessment dated 08/16/17, indicated he received regular diet with large portions.

During observation and interview on 10/02/17, at 12:20 p.m. nursing assistant (NA)-V was observed to bring R162 his room tray which had one brat, 1/2 corn on cob, a cup of baked beans and one ice cream cup. R162 stated that he had ordered two brats and two ice cream cups and that was it since he is on a high protein large portion diet. NA-V stated that he did not take his order and that was not on his diet and that is what

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| F 242 | Continued From page 20<br>he was supposed to have. R162 stated, "I know what I had on my meal ticket and that is not what I wanted." R162 then stated, "This is not what I had on my F----ing ticket and I never should have came here [the facility]."<br><br>In follow up interview on 10/03/17, at 8:00 a.m. R162 stated he never was offered the second brat or ice cream as he requested during lunch on 10/02/17.<br><br>During phone interview on 10/03/17, at 12:17 p.m. the facility's registered dietician (RD)-A stated she did not have R162's chart in front of her but thought R162 should receive a double meat diet so he should had received a two meat portion at lunch on 10/02/17, and recommended to talk to the facility's dietary manager.<br><br>During interview on 10/03/17, at 1:40 p.m. dietary manager (DM)-A stated R162 was on a regular large portion diet and stated the nursing assistant should have checked on his diet after he became upset and that he should had been able to have the two brats and double ice cream as he requested. | F 242 | | |
| F 244 SS=E | 483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br><br>(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br><br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. | F 244 | | 11/13/17 |

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| F 244 | Continued From page 21<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br><br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure they had followed up on concerns presented at resident council meetings to the residents. This affected 24 residents (R6, R10, R11, R12, R13, R14, R21, R31, R34, R39, R43, R44, R50, R58, R65, R66, R73, R79, R96, R106, R116, R127, R135, R179) who have participated in the resident council meetings.<br><br>Findings include:<br><br>During interview on 10/1/17, at 10:14 a.m. the resident council representative, R31 stated, "We are not getting anywhere with anything." R31 stated there have been concerns regarding closure of the resident store, understaffing at the facility, slow response to call lights, variance of time of medication administration in the morning from 7:30 a.m. and 11:30 a.m., and there was an extended period of time before residents who were incontinent received care by the facility staff.<br><br>R31 also stated personal grievances had been filed on 4/7/17, 4/14/17 and 9/11/7, related to staffing and provision of cares. He stated he had not yet received responses in follow up to the grievances filed, either in writing or by any staff. R31 stated he has kept the documents to demonstrate the concerns that had been submitted. | F 244 | Identified<br>1) The Resident council minutes were reviewed from March 2nd to September 7th. Identified concerns have been documented on a resident grievance report. The concerns were delivered to the appropriate department managers to address. The social service director will track concerns for follow up regarding the resident council minutes. The social service director will encourage residents to bring up concerns as they occur for immediate follow up.<br>Like<br>2) Resident council minutes will be viewed by the executive director or designee to ensure the director of social service is initiating a resident grievance form when needed and is tracking the completion of the grievance form for the resident council minutes. For continuity of care, resolution of the resident council complaints will be communicated to those residents who expressed the concern or grievance.<br>Education<br>3) The director of social service was educated on the resident council policy, grievance process, and minute taking with the proper follow through.<br>Monitoring | |

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| F 244 | Continued From page 22<br>A review of the resident council meeting minutes from 3/2/17 to 9/7/17 identified the following:<br><br>-3/2/17, resident concerns regarding the length of time it took to have call lights answered, and failure to provide care when lights were answered. The minutes also identified an update from the Ombudsman of the resident right to have the facilty follow up with residents if a complaint is filed and an investigation was completed. The meeting was noted to have been attended by the following resdient's: R6, R21, R50, R58, R65, R73, R12.<br><br>-4/6/17, information was provided to residents regarding the plans for the new smoking patio that will be built outside of the 1st floor double doors. The meeting minutes did not reflect concerns identified from the meeting of 3/2/17. The meeting was noted to be attended by the following residents:R10, R13, R21, R34, R58, R66, R79, R106.<br><br>-5/4/17, concerns regarding not enough staff and not receiving medications or cares on time. Previous concerns addressed or resolutions identified were not addressed in the meeting minutes. The meeting was attending by the following residents: R10, R11, R12, R13, R14, R21, R31, R34, R39, R43, R44, R50, R58, R65, R66.<br><br>- 6/1/17, concerns and requests were made related to the process for the resumption of the resident store and refreshment desired for the council meetings. The minutes did not address previous concerns or resolution to concerns identified. The meeting was attended by the following residents: R10, R11, R12, R21, R31, | F 244 | 4) Resident council minutes will be reviewed by the Executive Director monthly. Trends of resident council minutes will be reviewed by the Quality Assurance Committee on monthly bases. Executive Director will monitor for compliance.<br>Date of compliance: 11/13/17 | |

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| F 244 | Continued From page 23 | F 244 | | |

R44, R65, R66, R73, R106, R135.

-7/6/17, concerns were identified related to resumption of the resident store. The meeting minutes not address previous concerns or resolution to concerns identified. The meeting was attended R10, R11, R12, R21, R31, R43, R58, R106, R116, R179.

-8/3/17, The Resident Council president requested all nursing related complaints be routed to the director of nursing for follow through. The minutes also reflected the residents inquired whether legal services were available to sue the facility to implement nurses/aides being available. The minutes identified concerns management staff should be cut instead of front line staff (nurses, aides).
Resident attendance was not outlined in the meeting minutes to reflect members present.

-9/7/17, minutes did not address any responses to the concerns previously identified. There was a "new business" heading included potentially speaking with state legislators to change laws for aide care/staff aide to resident ratio. Resident attendance was not outlined in the meeting minutes to reflect which members were present.

During interview on 10/5/17, at 10:48 a.m. the director of social services (DSS) stated he had been acting as the liaison of the resident council since July of 2017. In this role, the DSS stated there continued to be discussion regarding the desire to resume the resident store, however, at this time there are no plans in place. The DSS stated there were multiple concerns identified regarding grievances related to nursing and staffing concerns. These concerns were routed to

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| F 244 | Continued From page 24<br>the executive director (ED) to review and follow through. The DSS stated staffing was frequently addressed but there has been no resolution of staffing concerns, and these residents were also able to file written grievances and noted R31 had expressed lack of follow through regarding written concerns.<br><br>During interview on 10/5/17, at 2:35 p.m. the ED stated the facility had identified the need for follow through on resident council concerns, however, stated there was not a plan formalized as to how this would be done. The ED stated grievances which had been filed were followed up on, however, stated prior to her appointment as ED approximately one month ago, there had not been a formalized process for follow up. The ED stated she was aware of residents concerns regarding staffing and provision of cares and they were still working on these concerns.<br><br>A policy, effective July 2015, titled, Resident Council identified under Procedure: bullet number four the council will report concerns/grievances to the ED and/or responsible party who will subsequently prepare a response to any concerns/grievances from the council. This response is to be provided in writing by the facility by completing the Resident Concern Report.<br><br>Although multiple resident council minutes identified resident concerns, there was no indication the facilty had completed follow up of these concerns, and promptly responded to the resident council members. | F 244 | | |
| F 247 SS=D | 483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE | F 247 | | 11/13/17 |

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| F 247 | Continued From page 25<br>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure notice of a new roommate was provided to 2 of 3 residents ( R130, R48) reviewed for facility admission, transfer and discharge practices.<br><br>Findings include:<br><br>R130's quarterly Minimum Data Set (MDS) dated 08/15/17, identified R130 was cognitively intact with no behaviors.<br><br>During interview on 10/02/17, at 2:22 p.m. R130 stated, "I will never forget the day my roommate moved in, I was watching television and he [R162] was brought in by the paramedics." R130 stated it was sometime this year in May, and stated he was never notified that he was getting a roommate by the facility.<br><br>Review of R130's medical record did not indicate R130 was notified of a new roommate.<br><br>R48's quarterly MDS dated 06/17/17, identified she was cognitively intact with no behaviors.<br><br>During interview on 10/01/17, at 3:59 p.m. R48 stated she has had at least five new roommates and was not notified of any new roommates prior to them moving in. | F 247 | Identified<br>1) Resident Grievance Reports completed for R48 and R130 for lack of notification for new roommates.<br>Resident 48 and Resident 130 have had notification of roommate or room change.<br>Like<br>2) Residents affected by all pending room changes have been notified of new roommate.<br>Residents with room changes and/or roommate changes have been reviewed and documentation of notices completed.<br><br>Education<br>3) Licensed nurses and Social Service department will be educated on Room and Roommate Changes policy and procedure. Facility will monitor documentation of roommate and/or room changes during the facility's meeting process as it occurs.<br><br>Monitoring<br>4) Room change notification forms will be reviewed every morning Mon-Fri in morning meeting to ensure notification has been completed. Forms will continue to be reviewed daily until results are reviewed with QAPI for 3 months. | |

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| F 247 | Continued From page 26<br><br>Review of R48's medical record did not indicate R48 was notified of new roommates.<br><br>During interview on 10/05/17, at 11:41 a.m. the director of social services (DSS) stated if they do a room change they give them seven days notice. The DSS stated the facility tries to let the residents know if they get a new roommate but do not always let them know. The DSS further indicated they do not document in the medical record if they had or had not been informed the resident of a new roommate.<br><br>A facility policy Procedure Room and Roommate Change effective January 2017, indicated: "notify the attending physician, all departments of the room and/or roommate change, and resident(s) receiving the roommate." The Procedure further indicated to monitor each resident's adjustment to the change in room and/roommate to account for adjustment issues. | F 247 | Executive Director will monitor compliance. | |
| F 278<br>SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the | F 278 | | 11/13/17 |

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| F 278 | Continued From page 27<br>assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 2 residents (R134, R24) in the sample reviewed for urinary continence/Foley catheter, and rejection of care behavior.<br><br>Findings include:<br><br>R134's significant change Minimum Data Set (MDS) dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had an urinary catheter. R134's care plan dated 10/2017, indicated he had a history of urinary tract infections and had a Foley catheter. R134's | F 278 | R134 Significant Change MDS ARD 7/13 was modified on 10/6/17 to correct catheter coding.<br>R24 Quarterly 5day MDS ARD 9/1 was modified on 10/6/17 to correct rejection of care coding.<br>Residents with rejection of care and catheters have been reviewed for accuracy and changes made as needed.<br>The IDT will receive the re-education on Tuesday Oct 17th regarding MDS accuracy standards per the RAI manual.<br>Re-education will be conducted by the Regional Director of Revenue Integrity or designee.<br>The Regional Director of Revenue Integrity or designee will audit three | |

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| F 278 | Continued From page 28<br>Urinary Incontinence Care Area Assessment (CAA) dated 7/27/17, indicated he needed total dependence with toileting and was incontinent of bowel and bladder and staff managed all incontinence cares and used incontinent products. The CAA assessment indicated he had urinary urgency and needed assistance with toileting. The CAA failed to indicate he had a catheter.<br><br>R134's hospice care plan dated 07/07/17, indicated he had alteration in bladder elimination and had a indwelling urinary catheter.<br><br>On 10/03/17, at 8:22 a.m. R134 was observed in the dinning room to have a catheter bag attached below his Broda chair (tilt and space positioning chair).<br><br>During interview 10/05/17, at 8:43 a.m. assistant director of nursing (ADON)-B stated R134 had went to the hospital in July 2017 when he was on third floor and transferred to first floor when he returned from the hospital. ADON-B stated his catheter bag should be changed weekly and the catheter should be changed monthly. ADON-B stated this was not put on his orders when he returned from the hospital and she was not sure if either had been completed since they did not have the orders.<br><br>During interview 10/05/17, at 10:00 a.m. MDS coordinator, licensed practical nurse (LPN)-J stated when R134 returned from the hospital there was no orders for a catheter, the nursing staff did not document R134 had a catheter so she did not indicate he had one on his significant change MDS dated 7/13/17. | F 278 | MDS's weekly for 2 weeks then monthly for 2 months to validate and monitor MDS coding accuracy.<br>Results of audits will be reviewed at the facility's QAPI meeting times 3 months.<br>RAI coordinator responsible for compliance. | |

F 278 | F 278

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R24's diagnoses, as indicated on the resident face sheet, dated 5/29/17, included obstructive sleep apnea. The quarterly MDS assessment dated 9/1/17, indicated R24 had intact cognition. The MDS also indicated R24 had daily rejection of cares.

During observation on 10//3/17, at 12:05 p.m. R24 was lying in bed in her room, awake, alert. R24 was dressed for the day, and presented without distress with the TV playing. Registered nurse (RN)-B entered the room and administered an oral medication to R24 without any difficulty.

A review of the Behavioral symptoms MDS report with a reference date of 9/27/17, covering the assessment period from 9/21/17 to 9/27/17, indicated R121 had "0" in the section "Rejection of Care - Presence & Frequency." The "0" indicated behavior (the rejection of care) was not present during the assessment period However, the MDS dated 9/27/17, section E, rejection of care, was coded as "3", which indicated rejection of care occurred daily.

During an interview on 10/4/17, at 10:50 a.m. licensed practical nurse (LPN)-J stated the MDS was based on the input the nursing assistants code in the "care tracker." LPN-J stated R121 had "no rejection of care", based on the data for the assessment periods from 9/21/18 to 9/27/17. LPN-J stated the social worker was responsible to complete the section related to rejection of care, and maybe he hit the wrong key. LPN-J stated there was "nothing documented" to indicated R24 had "daily" rejection of cares.

When interviewed on 10/4/17, at 2:41 p.m. the

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| F 278 | Continued From page 30<br>director of social services (DSS) stated he assessed R24 as having daily refusal of cares, because R24 had a C-PAP machine, and refuses to wear it. The DSS stated he coded that as a daily refusal of cares. The DSS stated he was incorrect after reviewing the MDS instructions. R24's refusal to wear the CPAP was a "resident choice," and not a refusal. The DSS stated R24's refusals should be in her care plan. The DSS acknowledged he realized the error and stated, "I coded that incorrectly."<br><br>A policy regarding completion of the MDS resident assessment was requested, but none was provided. | F 278 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive | F 279 | | 11/13/17 |

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care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R7) with respiratory failure, and 1 of 3 residents (R108) reviewed with behaviors.

Findings include:

R7's Admission Record, dated 9/14/17, identified diagnoses of morbid obesity with alveolar hypoventilation (a failure of the lungs to oxygenate adequately), obstructive sleep apnea, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia. R7's admission Minimum Data Set (MDS) of 8/16/17, indicted intact cognition and identified use of oxygen both prior to and during the stay at the facility. The MDS also identified R7 had use of BIPAP/CPAP (a device used to aid sleep apnea) both prior to admision and following the admission to the facility.

During observation on 10/1/17, at 9:57 a.m R7 was noted to have oxygen in place via a nasal cannula with liquid oxygen while up in wheelchair. R7 stated she was admitted to the facility on 8/9/17, however, was hospitalized on 8/19/17, related to respiratory problems and sepsis (an infection). She used oxygen therapy and a BIPAP prior to admission to the facility.

A review of the nursing progress notes identified R7 was hospitalized on 8/19/17. The admission history and physical (H&P) identified R7 was admitted with respiratory failure and septic shock. The Discharge Summary of 8/26/17, noted R7 was hospitalized with diagnosis of acute on chronic respiratory failure. The document identified R7 was experiencing septic shock,

1. R7's Plan of Care and Care Plans have been updated to reflect appropriate goals and interventions related to her respiratory diagnosis. R108's Care Plan and Plan of care have been reviewed and updated to reflect appropriate behavior monitoring with interventions related to the individual behavioral health needs.
2. Residents that reside at GVRH with a respiratory diagnosis requiring additional monitoring and skilled care have the potential to be effected by this practice. Policies and procedures have been reviewed and are current. Residents that have a diagnosis related to respiratory concerns have received chart reviews with updates made as appropriate. Updates to include CPAP/BiPAP settings per MD orders with monitoring settings regularly. Increased respiratory monitoring including daily lung sounds, oxygen saturation levels, liters of oxygen per physician orders with parameters if appropriate, and identified signs and symptoms of when to update the physician related to a potential change of condition. Resident's that reside at GVHR with a mental health diagnosis that require a behavioral health care plan for targeted and identified mood and behavior issues have the potential be affected by this practice. Residents with identified target mood and behavior issues have had a chart review with updates made as appropriate. Updates to include individualized interventions for staff to practice that are affective for decreasing or de-escalating behaviors that have the potential to impact the resident's highest level of practical

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| F 279 | Continued From page 33<br>acute psychosis, transaminitis (abnormal lab value indicating liver failure) due to a shocked liver.<br><br>A review of R7's Medication Adminsitration Record (MAR) and the Treatment Administration Record (TAR) were conducted and although the records initially identified the use of CPAP/BIPAP, it did not provide any specifications as to which settings are used or what to monitor on the machine for settings. The directions only outlined cleaning of the mask, humidifier bottle, and filling of the humidifier bottle.<br><br>R7's care plan, revised 8/17, listed R7 had a potential for nutritional problem, due to multiple medical problems, and respiratory status. However, the care plan did not direct staff to complete specific monitoring of R7's lungs, oxygen saturation levels, how many liters of oxygen to use, or what symptoms to monitor to identify any changes or decline in respiratory status.<br><br>On 10/4/17, at 9:49 a.m. the assistant director of nursing (ADON)-B confirmed R7's current care plan and confirmed the care plan did not identify any respiratory problems or necessary interventions, with the exception of how it may have impacted her nutrition. She confirmed R7 had been recently hospitalized for respiratory problems. The ADON-B stated this should be included in the resident's care plan and should have been reviewed and updated following her return from the hospital.<br><br>R108's facility face sheet, undated, identified R108 had diagnoses of intracranial injury, | F 279 | wellbeing for both the individual and other individuals residing at the center. Interventions to be communicated through communication tools currently being utilized with non-affective interventions being communicated so revisions can occur.<br>3. Clinical leadership and Licensed Nurses have been educated on clinical monitoring and required Care Planning as it relates to respiratory monitoring and interventions. Staff in all disciplines have been re-educated on the Target Mood and Behavior program as it relates to individualized interventions.<br>4. DON/Designee will audit the charts of 3 residents with a respiratory diagnosis to ensure appropriate monitoring and documentation 3 times a week for 4 weeks then monthly times 2 months. DOSS/Designee will audit Target Mood and behavior Program and observe interventions for effectiveness for 3 residents weekly x 4 weeks, then 3 residents monthly x 2 months. Results will be brought to QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br>DON will monitor for compliance | |

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psychotic disorder, paraplegia disorder, schizoaffective and bipolar disorder. R108's quarterly MDS dated 7/24/17, identified he had intact cognition, disorganized thinking, verbal altercations and needed staff assistance for activities of daily living. The behavior Care Area Assessment (CAA) worksheet dated 2/24/17, identified resident displayed delusions and hallucinations which could cause behavior problems.

During observation on 10/3/17, at 10:12 a.m. R108 was yelling in the entry way of the nursing home at (R71 and R201) stating, "Look at yourself in the mirror and you will see the definition of ugly," and R71 yells back. Social Service (SS)-B whom was in the area talks to R71 who is very upset yelling (R108) calls us names all the time and nothing happens, R71 leaves the area. R108 remained in area after the confrontation, looking around, no one talked with R108 about his yelling at R71. At 10:16 a.m., four minutes later, R71 was outside of the administration office yelling at executive director (ED), and assistant executive director (AED)-A, AED-B and director of quality. R71 very upset yelling, he was "tired of him [R108] yelling'" and calling him "an Indian", and (R201) a "Nigger". You have not done anything about this, and I am tired of it. All you tell (R108) to do is calm down, nothing gets done and I am sick of it. You have no idea what I or (R201) have gone through when we get called those's names. "I am sick of it!" The ED, and AED-A tried to calm R71 down. R71 kept telling administration (R108) "bums cigarettes" from (R192) all the time. I have heard him get mad at her, she doesn't like it when (R108) goes off on people, so she gives into him and he gets 3-4 cigarettes a day from her. While

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R71 was yelling at administration. R108 was sitting in his wheelchair approximately 15 feet away, smiling and grinning with enjoyment while watching R71 yelling at the facility administraiton staff.

R108's Mood and Behavior Assessment Care Plan review on 8/8/17, identified bipolar affective disorder, and used antipsychotic medications, and antianxiety medications. The interventions included, monitor for side effects, periods of altered perception or awareness, disorganized speech, lethargy, changed in cognitive level, hallucinations and constipation. There were no staff interventions idenfied to assist staff on how to deal with R108's behavior of being demanding, using profanity and name calling of other residents to help decrease these behaviors.

During interview on 10/4/17, at 9:23 a.m. with ADON-A and SS-A both stated, R108 has lots of verbal behaviors of yelling at staff and residents with very "colorful" words. He sees ACP on a regular basis but also refused to see them as well, his main focus is cigarettes with his behaviors. Associated Clinic Psychology (ACP) told us to develop a cigarette plan, and roll his cigarettes so his money lasted longer and this would stop him from bothering other residents. He started to sell them to other residents, then he complained they were not packed right and did not like the taste, so he (R108) stopped this program at the end of June 2017. We have not implemented any other behavior plan, or care plan for R108, we just do our best.

A policy titled Care Plans, revised January 2017, identified the care plan: "Provides information regarding how the causes and risks associated

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| F 279 | Continued From page 36 with issues and/or conditions can be addressed to provide for a resident's highest practible level of well being." The procedure identified under bullet one: "Initate the appropriate Care Plan according to the RAI (resident assessment instrument) process and as needed with resident change in condition. | F 279 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- | F 280 | | 11/13/17 |

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(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

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| F 280 | Continued From page 38<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to revise the care plan to include specific feeding instructions for 1 of 1 residents (R19) identified with swallowing difficulties received safe and appropriate assistance with eating. In addition, the facility failed to revise the care plan to include an indwelling catheter for 1 of 2 residents (R48) reviewed for justification of use for a catheter.<br><br>Findings include:<br><br>R19's Admission Record, undated, indicated that he had dementia and dysphagia. R19's Minimum Data Set (MDS)dated 09/08/17, indicated he needed extensive assist of one with eating and had no swallowing disorder. R19's Care Area Assessment (CAA) dated 09/08/17, indicated that he required assist with feeding at meals and tolerated a mechanically altered diet.<br><br>A Discharge Summary Note dated 11/30/16, indicated R19 had aspiration pneumonia, and x-ray with bilateral infiltrates.<br><br>R19's speech therapist note dated 08/02/17, indicated PT (patient) seen for skilled ST services to address dysphagia (difficulty swallowing) and | F 280 | 1. R19's Care plan has been reviewed and updated to reflect dietary orders. R48's catheter has been reviewed for justification and Care Plan has been updated to reflect changes.<br>2. Residents that reside at GVHR with altered diets have the potential to be affected by this practice. Policies and procedures related to altered diets care planning have been reviewed and are current. Residents with altered diets have received a chart review with updates made as appropriate to reflect current dietary orders. Policies and procedures related to catheter care planning have been reviewed and are current. Resident with catheters have received chart reviews and updates have been made as appropriate.<br>3. Clinical leadership and licensed nursing staff have been re-educated on updating resident care plans as changes occur so it reflects current and active plans of care.<br>4. DON/designee will audit 3 charts per week for 4 weeks then monthly times 2 months to ensure appropriate and up to date care planning for both resident with | |

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| F 280 | Continued From page 39<br>complete final session to receive discharge documentation. Therapist followed up with nursing staff regarding use of printed compensatory swallowing strategies to reduce aspiration risk. A 24-hour log updated for discontinuation of services due to inability to progress due to dementia and inability to follow cues. Nursing staff to implement use of compensatory swallowing strategies and monitor for ongoing signs and symptoms of aspiration.<br><br>A 24 Hour Status Report dated 08/02/17, indicated: "D/C [discontinue] from ST today continue puree/honey thick liquid diet. Printed strategies at patients table to follow during meals."<br><br>The speech therapy instruction sheet indicated the following:<br>* Bite sizes should be 1/2 spoonful of puree<br>* Use spoon to give honey thickened fluids (1/2 spoon size)<br>*Allow patient to clear mouth completely before giving another bite<br>* Do not put more food in patient's mouth if he is still chewing<br>* If he begins coughing, do not give more food until coughing discontinues.<br><br>R19's care plan lacked the specific feeding instructions indicated by the speech language pathologist (SLP)-A.<br><br>R48's Urinary Incontinence and Indwelling Catheter CAA dated 3/27/17, indicated R48 was occasionally incontinent of urine and did not have an indwelling urinary catheter.<br><br>R48's progress note dated 5/1/17, at 9:00 p.m. | F 280 | altered diets and resident with catheters. Results will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br>DON will monitor for compliance. | |

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| F 280 | Continued From page 40<br>indicated R48's hospice nurse inserted a Foley catheter and was to be maintained by hospice.<br><br>R48's quarterly MDS dated 6/17/17, indicated R48 had an indwelling catheter.<br><br>On 10/3/17, at 9:37 a.m. R48 was observed in her room to have a catheter attached to her right leg draining yellow urine.<br><br>R48's urinary continence care plan dated 8/7/17, indicated R48 was occasionally incontinent of urine. The care plan did not indicated R48 had a Foley catheter.<br><br>During interview on 10/5/17, at 10:14 a.m. assistant director of nursing (ADON)- A stated R48's care plan should have been revised to reflect the use of a Foley catheter, and list interventions for staff to maintain the catheter.<br><br>The facility policy Care Plans dated 7/15, indicated: "The center follows the CMS RAI philosophy and process on care planning. The comprehensive care plan should be an interdisciplinary communication tool that must have measurable objectives with time frames and describes the services to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing. The care plan must be reviewed and revised according to the RAI process, and services provided or arranged must be consistent with each resident's written care plan." | F 280 | | |
| F 282<br>SS=E | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans | F 282 | | 11/13/17 |

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| F 282 | Continued From page 41<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure care plan interventions was implemented as directed for 2 of 3 residents (R134, R121) who required staff assistance for repositioning; 1 of 1 resident (R121) whom required range of motion. In addition, skin monitoring not completed for 1 of 2 resident (R6) with a current pressure ulcer and activities of daily living (ADL's) were not completed for 3 of 5 residents (R183, R55, R2) dependent upon staff for ADL's.<br><br>Findings include:<br><br>REPOSITIONING:<br><br>R134's significant change Minimum Data Set (MDS) dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with bed mobility, transfers and toileting. The MDS further indicated he was at risk for pressure ulcers and had no pressure ulcers.<br><br>R134's Skin Integrity Assessment: Prevention And Treatment Plan Of Care dated 10/03/17, indicated he required frequent turning, and was to be repositioned every two hours and to provide a pressure relief surface. In addition the care plan indicated he was incontinent of bowel and bladder. R134's Actual/Potential For Infection | F 282 | 1. R134, R121, R6, R183, R55, and R2 have had their medical records and reviewed and updated as appropriate. Services related to repositioning, range of motion, skin monitoring, and ADLs are being completed per care plan interventions. A PUSH tool has been completed for R6.<br>2. Residents that reside at GVHR with care planned interventions related to repositioning, range of motion services, skin monitoring, and ADL assistance have the potential to be affected by this practice. Policies and procedures have been reviewed and are current. Resident's requiring assistance with above services have received a medical record review and interventions have been updated as appropriate. Skin monitoring will be overseen by clinical leadership to ensure completion of all required assessments and effectiveness. Dependent residents who require ADLS services will receive timely and appropriate care that includes but is not limited to; scheduled and routine bathing per resident choice, nail care weekly and as needed, daily and PRN grooming of hair and facial hair, incontinent care per residents POC and when visible soiled, clothing will be clean | |

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| F 282 | Continued From page 42<br>Care Plan dated 10/17, indicated he had a history of urinary tract infection and had a foley catheter.<br><br>During continuous observation 10/03/17, from 8:35 a.m. to 11:07 a.m. ( 2 hours and 32 minutes) R134 was observed to be sitting in his Broda chair (tilt and recline positioning chair), without being repositioned/toileted or checked/changed. At 8:35 a.m. R134 was observed across from the nurses station on the first floor, at 9:00 a.m. R134 was moved across from the nurses station in the hall, at 9:12 a.m. R134 was asleep in the Broda chair, at 9:30 a.m. registered nurse (RN)-K hospice nurse moved R134 from the hall to the dinning room. At 10:02 a.m. RN-K hospice nurse moved R134 back into the hall across from the nurses station. At 10:22 a.m. R134 was asleep in the hall in his Broda chair. At 10:42 a.m. R134 was still in hallway in chair asleep. At 11:00 a.m. he was still asleep. At 11:07 a.m. surveyor informed nursing assistant (NA)-M and NA-J of findings.<br><br>During interview 10/03/17 at 11:01 a.m. NA-N stated that he had repositioned and checked him for bowel incontinence right after breakfast around 8:30 a.m.<br><br>During interview 10/03/17, at 11:12 a.m. NA-M stated she had assisted NA-N right after breakfast with repositioning R134. She indicated she did not have a chance to reposition him again because they did not have enough staff and that he needed assist of two so she could not reposition him timely.<br><br>During observation 10/03/17, at 11:30 a.m. (a total of 3 hours) NA-J and NA-N was observed to reposition and check R134. R134 was continent | F 282 | and neat and free of holes/rips/tears, and residents will be monitored for increased odor and offered hygiene services.<br>3. Licensed and unlicensed staff have been re-educated on following the resident's plan of care related to repositioning, ROM services, skin monitoring, and ADL services.<br>4. DON/Designee will audit 5 residents weekly for 4 weeks then monthly times 2 months for repositioning, ROM services, skin monitoring, and completion of ADL services. Results will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br>DON will monitor for compliance. | |

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of bowel and had a catheter for urine. In addition R134's skin was intact with no open areas or redness of the skin.

Although R134's care plan indicted he was to be turned and repositioned every two hours the facility failed to implement his care plan and R134 went approximately three hours without being repositioned.

R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent upon and required the physical assistance of two staff for bed mobility, eating, dressing, toileting and personal hygiene. The MDS indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue).

R121's "Skin Integrity Assessment: Prevention and Treatment Care Plan", dated 4/17, identified pressure ulcer to coccyx, and directed a turn and reposition program with a frequency of "Q2" (every) two hours.

During observation on 10/3/17 at 11:32 a.m., R121 was lying in bed in his room, dressed in a gown and covered with a white sheet, to which a call light was clipped. An alternating pressure mattress was on the bed and running, and set at "4". R121 was laying on his back, facing the exit side of bed, with a pillow visible from under the cover, slightly lifting his left, back side. Under the covers, the shape of a pillow was seen, placed between R121's legs, as well as heel boots placed bilaterally on R121's feet.

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| F 282 | Continued From page 44<br>During continuous observation from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed remained unchanged. At 1:58 p.m., nursing assistants (NA)-D and NA-B entered R121's room, closed the door behind them, and announced to R121 they were going to "check you" and "reposition you." Working on each side of R121's bed, NA-D and NA-B raised the bed to a working height, and began their cares, talking with R121 as they preceded. R121's brief was checked and was not wet. NA-B removed the pillow from under R121's left side, and NA-D took out the pillow between his legs. Together NA-B and NA-D pulled R121 up in bed, then refitted the pillows between his legs, and now placed R121 slightly facing the window, with a pillow under R121 right back side. The pillow between R121 legs was replaced, and legs adjusted, then R121 was covered with the bed sheet. Before NA-B and NA-D exited the room, they removed gloves and washed their hands.<br><br>During an interview on 10/3/17 at 2:06 p.m., nursing assistant (NA)-D stated the last time R121 was "done" (repositioned) was at 11:30, and now it was two o'clock. NA-D stated we got busy down there, and that (R121) should be checked and turned every two hours. NA-D stated "it was late."<br><br>When interviewed on 10/3/17 at 4:30 p.m., registered nurse (RN)-B stated it was his expectation that residents be turned "timely" so that the wound can be taken care of an not break down more. RN-B stated R121 had a open, stage 4 pressure ulcer, and also it was "not acceptable" that R121 was not turned as he was supposed to be. RN-B stated he thought some of the aides needed more training and needed to be | F 282 | | |

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more aware of the residents' care needs.

When interviewed on 10/4/17 at 8:52 a.m., the assistant director of nursing (ADON)-C stated she "would expect" R121 to be turned and repositioned every 2 hours as care planned.

RANGE OF MOTION

R121's Restorative Program History report, printed 10/4/17, indicated R121's passive ROM program goal to be: Resident will maintain current range of motion with assistance of doing PROM to bilateral extremities twice a day for 15 reps each time. The program directed: 1. Explain procedure; 2. Perform PROM to bilateral lower extremities and; Report to nurse any complaints of pain, refusals. R121's mobility care plan, dated 4/17, identified contractures and muscle stiffness as a target problem.

During observation on 10/3/17 at 8:18 a.m., R121 was lying in his bed in his room, facing the window, a pillow under his left side. R121's arms were at his side, elbows folded and forearms at 45 degree angle from his elbow, and situated upon his stomach. R121 wore heel boots, bilaterally, on his feet. During continuous observation from 8:18 am to 11:32 a.m., R121 remained lying on his bed in his room. At 9:29 a.m., nursing assistant (NA)-D and registered nurse (RN)-B repositioned R121. At 11:32 a.m., RN-B, NA-D and NA-B assisted with R121 with a dressing change and repositioning. At 1:58 p.m., R121 was again repositioned by NA-B and NA-D. R121 was not offered nor was provided any range of motion during any of the visits by nursing staff.

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During interview on 10/3/17 at 2:06 p.m. NA-D stated she assisted R121 only to reposition and did not do any kind of ROM exercises. NA-D stated she "did not think" R121 has any range of motion or exercise program.

When interviewed on 10/3/17 at 4:38 p.m., RN-B stated R121 did not have any orders for restorative nursing, however, R121 could benefit from a ROM program, so (R121) could keep his arms and hands "more limber."

During observation of the morning routine on 10/4/17 at 9:42 a.m., NA-A and NA-C assisted R121 with morning cares, including repositioning and oral cares. There was no provision or offer to complete range of motion for R121 during the morning routine. When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a range of motion program, and has not assisted him with that. NA-C stated often therapy often worked with res in their rooms, but has not seen anyone work with R121 in his room. NA-C stated she did not perform ROM for R121.
During an interview on 10/4/17 at 9:59 a.m., NA-A stated she did not think R121 had any range of motion program, and if he did, we would have had "someone from therapy" show us what to do. NA-A stated she did not help R121 with any exercise or range of motion.

When interviewed on 10/4/17 at 8:43 a.m. the assistant director of nursing (ADON)-C stated R121 had a restorative program and futher the aides should be completing that task, during cares or when repositioning. ADON-C questioned how R121 could be 'refusing' the program because of his current disposition and stated the ROM program was to be completed

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twice daily, 15 reps each time. ADON-C also stated the instructions for restorative program in the care tracker were part of the care plan, and she "expected" R121 to receive range of motion services as identified.

LACK OF SKIN MONITORING:

R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs), had unhealed pressure ulcers and remained at risk for further pressure ulcer development.

R6's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 8/7/17, identified R6 was at moderate risk of pressure ulcer development and had a history of past pressure ulcers. The care plan listed several interventions including keeping his skin clean and moist, encouraging him to reposition every two hours and, "Complete Push [Pressure Ulcer Scale for Healing] Tool Weekly."

R6's medical record was reviewed and lacked any completed PUSH tools as directed by R6's care plan.

During interview on 10/3/17, at 2:33 p.m. RN-A stated a care plan was used to, "direct us," in how to provide care for a resident, and staff should be implementing the interventions. RN-A stated the PUSH tool was used to help determine if the wound was, "getting bigger, getting worse or stalled." Further, RN-A stated the PUSH tools were not currently being completed, "at this moment," but would be on a weekly basis going forward.

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When interviewed on 10/4/17, at 1:37 p.m. the interim director of nursing (DON) stated a care plan was used to, "keep all staff informed," of resident needs and staff were expected to keep abreast of the interventions listed on it. Further, the DON stated the PUSH tool was considered part of a comprehensive skin assessment and could help determine if new interventions were needed for a pressure ulcer.

ADL'S NOT PROVIDED:

R183's Admission Record, dated 10/5/17, identified multiple medical diagnosis including heart failure, diabetes, morbid obesity, hypertension, lymphedema, chronic respiratory failure and urinary retention.

R183's admission Minimum Data Set (MDS) completed on 8/3/17 identified resident was cognitively intact with moderate symptoms of depression. R183 required extensive assistance of one to two staff to complete ADL's including dressing, grooming, bathing, toileting and mobility.

A review of R183's care plan noted initiated 7/28/17 identified R183 required personal assistance with personal hygiene/grooming/dressing/undressing.

During observation and interview on 10/1/17 at 3:44 p.m., R183 was resting on his bed, covered only with a sheet. R183 stated he was dependent on staff for provision of care, stating " I can turn my light on, but I don't know how long it will take them to come." R183 did acknowledge he had called 911 when he had been left on the

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commode for 45 minutes. He stated the staff responded within five minutes after he called 911. R183 stated his bath is scheduled for Mondays, but had not yet received since admission to the facility which was more than two months ago. R183 stated to receive a shower he would need to be transported on a gurney and assisted to shower while on the cart. R183 stated he has received a "A whore bath", when he was assisted to wash up with a basin. R183 was noted to have a strong, foul odor of perspiration and other body odors.

During observation and interview on 10/2/17, at 12:23 p.m. R183 stated he was going to get dressed today but didn't feel real clean and his last bed bath was about two weeks ago. R183 was dressed in a hospital gown at this time and was noted to have a increased personal odor of perspiration and other more personal odors than had been noted during observation on 10/1/17. The personal odor was very prominent in the room, and lingered into the hallway. R183 stated he chose note to get up for lunch today because it took too long to get back to bed, he was uncomfortable and has had a history of pressure ulcers. Following this interaction, the facility bath schedule was posted at the nurses station and identified R183 received his bath on Tuesday evenings.

During interview on 10/4/17, at 7:05 a.m. R183 stated he had received a bed bath last evening (10/3/17). After his bedbath he requested to get up out of bed and was asked why he wished to get up. R183 stated he had to instruct staff to change his bed linens following his bath because he wanted fresh bed linens. R183 stated linens were changed as requested.

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During interview on 10/4/17, at 2:19 p.m. nursing assistant (NA)-S stated he had provided assistance to provide a bedbath for R183 and stated they provided care according to the care plan. R183 could request what he wanted. NA-S stated when providing routine cares, and not a bedbath, it is important to provide catheter care, emptying the catheter, and performing hygiene to the catheter.

A review of the physician progress notes of 10/2/17 identified R183 did not wish to pursue catheter removal, noting "I can't even get someone here to help me shit. I won't be demeaned any further."

During interview on 10/5/17 at 9:59 a.m. the assistant director of nursing (ADON)-B stated R183 was very impatient and went on to state if he does not receive immediate assistance, he will attempt to self transfer, or call 911. ADON-B stated the call light should be answered immediately, with assistance provided within ten minutes, however, it may take longer to summon adequate staff to provide assist of two for transfers. ADON-B stated she was unaware of concerns regarding personal odors, and expressed it was the expectation residents are washed up with morning and bedtime cares, including washing of face, hands, pericare, armpits, and application of lotion and deodorant. ADON-B stated residents hair are routinely washed on bath day. The resident care tracker was reviewed from 9/28/17 through 10/3/17, with notations made resident had received two bedbaths in one day. ADON-B stated he wouldn't gotten two in a day ADON-B stated if short staffed, and they are unable to complete it, the

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task would be passed on to the oncoming shift to complete. The ADON-B state it would be appropriate for him to be washed up and receive a bath at the time the odor was noted.

R55's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. Diagnoses included dementia and depression.

R55's ADL/Mobility care plan last dated 4/10/17, included a goal for R55 to be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene and dressing.

On 10/1/17, 9:50 a.m. R55 was seated in her wheelchair in the doorway to her room. A dark brown substances was noted to be under her long fingernails on her right hand.

During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap.

On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.

During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)- A stated nail care should be done daily with cares if visibly

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dirty, otherwise weekly with their showers. ADON-A stated residents should not be sitting in urine soiled clothing. ADON-A stated R55's care plan should have been followed.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently incontinent of urine, with moisture associated skin damage and diagnosis was schizophrenia.

R2's ADL/Mobility last reviewed on 8/5/17, indicated R2 would be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADL's and at times refused shaving. The care plan lacked approaches to refusal of cares.

During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweat pants were saturated with urine in the front and back, as well as the right lower side of his shirt. Multiple staff were located around the nursing desk and no staff members offered to assist him with toileting. R2 hair was uncombed and sticky up in multiple places. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated with urine. R2's room had a strong odor of urine present that could be smelled in the hallway.

On 10/3/17, at 10:12 a.m. R2 was walking in the hallway in front of the nursing desk, his shoes

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were untied, his hair was uncombed and sticking up in multiple places, his gray t-shirt had a tear in the back of the color from one side of the neck to the other. ADON-A approached R2 and offered to tie his shoes. R2 allowed ADON-A to tie his shoes; however ADON-A did not offer to take him back to his room and help him change his shirt or comb his hair.

On 10/4/17, at 6:51 a.m. R2 was sitting in the dining room watching television. His hair was uncombed and was sticking up in multiple places. His gray t-shirt had a quarter sized hole in the front. R2 was in the dining room until 9:06 a.m. when he walked down the hall towards his room and laid in bed. Staff did not approach R2 and offer to change his shirt or comb his hair, during this time.

During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are aware when R2 was soiled,and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and wasn't sure who did.

During interview on 10/5/17, at 9:39 a.m. ADON-A stated R2's current care plan needed to be looked at for revisions; however staff did not follow the current care plan and should have. ADON-A stated R2's care plan directed staff to physically assist with personal hygiene, grooming and dressing.

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| F 282 | Continued From page 54<br><br>The facility policy Care Plans dated 7/15, indicated " The center follows the CMS RAI philosophy and process on care planning. The comprehensive care plan should be an interdisciplinary<br>communication tool that must have measurable objectives with time frames and describes the services to be provided to attain or maintain the resident ' s highest practicable physical, mental and psychosocial wellbeing. The care plan must be reviewed and revised according to the RAI process, and services provided or arranged must be consistent with each<br>resident ' s written care plan...Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident ' s function status." | F 282 | | |
| F 309 SS=J | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of | F 309 | | 11/13/17 |

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practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R19) identified with swallowing difficulties received safe and appropriate assistance from nursing staff when there was an identified concern while feeding a resident. The findings constituted an immediate jeopardy (IJ) situation for R19, with the potential for serious harm, injury or death.

The immediate jeopardy began on 10/04/17, at 8:12 a.m. when the resident was observed to have on-going issues with coughing while eating. Staff were not following the feeding program established by the speech language pathologist due to dysphagia (difficulty swallowing). The executive director (ED), interim director of nursing (DON), director of clinical services (DOCS), assistant ED-A and ED-B were informed of the immediate jeopardy on 10/04/17, at 4:15 p.m..

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R108 will have a behavior plan of care developed with assistance from psychiatrist and ombudsman. Plan of care will assist and guide the staff to manage resident's behaviors.
Interventions specific to R108's interaction with others have been created to ensure other residents are protected and not affected by resident's target mood and behaviors. Plan of care will be reevaluated quarterly and as needed with changes in condition or as behaviors change or escalate.
R48 is having pain medication administered when scheduled and timely upon request. Pain assessment will be completed to ensure adequate pain management.
R134 had catheter replaced and an order received from the MD for ongoing catheter

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The IJ was removed 10/05/2017, at 2:54 p.m., but non-compliance remained at the lower scope and severity of (D) isolated, with potential for more than minimal harm that is not Immediate Jeopardy.

In addition, the facilty failed to ensure a behavior plan was in place for 1 of 1 residents (R108) with bullying behaviors which contributed to verbal altercations. Also, the facility failed to comprehensively assess for pain, and provide pain medications timely for 1 of 3 residents (R48) who had complaints of pain. The facility also failed to coordinate hospice services for 2 of 2 residents (R138, R48) reviewed for hospice.

Finding include:

EATING:

R19's Admission Record undated indicated that he had dementia and dysphagia (difficulty swallowing). R19's annual Minimum Data Set (MDS) dated 09/08/17, indicated he needed extensive assistance of one with eating and had no swallowing disorders. R19's Nutritional Status Care Area Assessment (CAA) dated 09/13/17, indicated he required assistance with feeding at meals and had a need for special diet or altered consistency which might not appeal to resident. The CAA further indicated he received sufficient eating assistance.

A Discharge Summary Note dated 12/02/16, from North Memorial Medical Center, indicated he was hospitalized from 11/30/16 to 12/02/16. The Discharge Summary note identified he had aspiration pneumonia, and x-ray with bilateral infiltrates of the lungs (something that has gotten

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care. Facility will coordinate with hospice to deliver care and communicate resident's needs.
R48 will have care coordinated with facility and hospice agency. Facility will have meeting with hospice to ensure proper communication and care coordination.
R19 will be assisted with eating in a safe manner by licensed nurses, NARs, and speech therapists. R19 care plan and nursing assistant care delivery guide were updated with speech therapy recommendations. Meal ticket for R19 was updated to alert staff to refer to feeding instructions. Treatment record updated to have licensed staff (nurses) monitor through visual observation that feeding recommendations are being followed at breakfast, lunch, and dinner.
Specific education for R19 was provided to nurses and NARs regarding feeding instructions. Feeding instructions include provide alternating ½ spoonful of puree and ½ spoonful of thickened liquids and waiting for mouth to clear. Respiratory therapist completed a respiratory assessment on R19 on 10/4/17.
Physician was updated on 10/4/17 regarding increased coughing at meal no new orders were received.
Immediate verbal education was provided to Employee 1 (LJ) that was assisting R19 with feeding and instructed that only licensed nurses and NARs are able to assist residents with eating. Employee was suspended pending the outcome of the investigation.

Residents with behaviors that can

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in to the lungs from the outside. Any abnormal density will show up in the otherwise air filled lungs. Usually the infiltrate will mean pneumonia, or some sort of infection with edema/swelling that is in the lung).

R19's Speech Therapist note dated 08/02/17, indicated PT (patient) seen for skilled ST services to address dysphagia and complete final session to receive discharge documentation. Therapist followed up with nursing staff regarding use of printed compensatory swallowing strategies to reduce aspiration risk. A 24-hour log updated for discontinuation of services due to inability to progress due to dementia and inability to follow cues. Nursing staff to implement use of compensatory swallowing strategies and monitor for ongoing signs and symptoms of aspiration.

A 24 Hour Status Report (communication report for nursing staff) dated 08/02/17, indicated: "D/C [discontinue] from ST today continue puree/honey thick liquid diet. Printed strategies at patients table to follow during meals."

The speech therapy instruction sheet directed staff to do the following swallowing strategies:
* Bite sizes should be 1/2 spoonful of puree
* Use spoon to give honey thickened fluids (1/2 spoon size)
*Allow patient to clear mouth completely before giving another bite
* Do not put more food in patient's mouth if he is still chewing
* If he begins coughing, do not give more food until coughing discontinues.

During observation on 10/01/17, at 12:12 p.m. nursing assistant (NA)-B was observed to give

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potentially affect others have been re-assessed for target mood and behaviors and care plans have been developed and communicated with staff. Plan of care to include interventions and recommendations to deescalate behaviors and protect other potential resident that could be affected. Behaviors occurring at the center will be monitored and reviewed daily based off triage reports and followed up on as appropriate. Residents will receive pain medication per physician orders. Residents on hospice will have care coordinated with hospice agencies. ADONs will attend hospice care conference in order to communicate resident needs and coordinate care. Residents with catheters have been reviewed to include orders for management of catheter. Pain occurring at the center will be monitored and reviewed daily based off triage reports and followed up on as appropriate. Team including nurse managers, speech therapy, dietary manager, registered dietician, DON, and ED reviewed all residents that required special feeding needs. Residents in facility were identified for potential difficulties with eating through visual assessment during meals. Two other residents were identified to have like concerns. R97 was assessed by speech therapy and occupational therapy for feeding technique on 10/4/17. R97 requires food to be cut in small pieces and food placed on left side. Resident meal ticket, Care plan and NAR care delivery guide were updated with recommendations. Resident

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| F 309 | Continued From page 58<br>R19 a drink of his juice bringing his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited from him to stop and then continued to give him a teaspoon full of his potatoes, and then a teaspoon of his pureed roast beef and he coughed again. At 12:19 p.m. NA-B fed him a level teaspoon full of his mashed potatoes and he coughed again. NA-B stated to R19 'It's ok" and gave him a drink of his juice from his cup. At 12:20 p.m. the surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the instructions that were on the window sill of the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive 1/2 teaspoons of food and liquids at a time. NA-B then took the teaspoon at the table and placed in his honey thickened juice and proceeded to feed him 1/2 teaspoons of his food and beverages and his coughing had decreased.<br><br>During observation 10/04/17, at 8:12 a.m. HR-A was observed in the first floor dining room assisting R19 with eating. R19 had scrambled eggs, pureed sausage, oatmeal and honey thickened cranberry juice. At the same table directly across from HR-A, sat assistant director of nursing (ADON)-B whom was assisting R134 with eating. HR-A gave R19 a level teaspoon full of pureed sausage and then immediately gave a heaping teaspoonful of his oatmeal, without first waiting for R19 to swallow the spoonful of pureed sausage before immediately giving a heaping spoonful of oatmeal to R19. R19 immediately | F 309 | B is going to be treated by speech therapy for ongoing treatment. Resident B has identified orders on 10/5/17 that resident is NPO. MD will be present next week for evaluation. Care plan and NAR care delivery guide updated with new orders.<br><br>Education will be provided to staff on behavior management plans and interventions for resident's exhibiting behaviors that affect others and where information is located. Licensed staff will be educated on pain management and delivering pain medication per physician order. Licensed staff will also be educated on hospice role in the delivery and coordination of care.<br>Education was provided to staff including leadership team, nurses, NARs, social service, dietary, maintenance, and human resources regarding only nurses with a current license, nursing assistants currently on the registry or speech therapists may assist residents to eat on 10/4/17 and 10/5/17. Education was provided to nurses and nursing assistants to include: residents with special feeding instructions will be indicated on the meal ticket to refer to the nutrition services binder which will be located on the juice cart in the dining room, and/or laminated card placed at the table. Staff is to stop feeding and report to nurse immediately if any excessive coughing, swallowing issues, or holding food in mouth.<br>Education will be provided to all staff present in building on 10/4/17 and 10/5/17. Mandatory education regarding special feeding instruction program will be | |

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| F 309 | Continued From page 59<br>started to cough, loudly turning his head away from HR-A to the right. HR-A stopped feeding him and rubbed his back and waited for him to stop coughing. HR-A then brought R19's glass of honey thickened cranberry juice just below his chin and began spoon feeding R19 three spoonfuls of thickened juice, one after another without first waiting for R19 to swallow each bite. HR-A fed R19 a full teaspoon of thickened juice, not a half teaspoon as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his pureed sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A while she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was not following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scrambled eggs, pureed sausage, and half of his oatmeal and 3/4 of his honey thickened cranberry juice. ADON-B left the same table HR-A was assisting R19 and NA-M then sat down to assist R134 across the same table R19 was sitting at. At approximately 8:25 a.m. SLP-A entered the dining room, and surveyor informed her of the above observation. HR-A was removing R19's clothing protector and SLP-A immediately walked up to the table and instructed HR-A she should have been following her recommendations of bite sizes | F 309 | provided to all employees before they are able to work. Notification will be posted by timeclock to check with nurse manager to receive mandatory education prior to working. This education will be provided ongoing to new employees during orientation and annually to all staff. Feeding instructions will be reviewed by nurse manager and dietician quarterly and with significant changes in condition. Nurse managers will verify that feeding instructions are available in binders and laminated cards are available at meals – quarterly and with any changes.<br><br>Social Service will complete weekly audits of 3 residents for 4 weeks then monthly times 2 months for compliance with behavior management plan of care. Audits to consist of ensuring behavior interventions being applied appropriately and that they are effective based off resident response. DON or designee will complete assessment of pain management of 10 residents a week for 4 weeks then monthly times 2 months to include completion of pain assessment, administration of pain meds as ordered and/or requested, and follow-up completed if plan of care for pain management ineffective. DON or Designee will audit 1 resident with a catheter weekly for 4 weeks then monthly times 2 months for appropriate diagnosis and orders for care. DON or designee will audit 1 resident's plan of care weekly for 4 weeks then monthly times 2 months for coordination of care with hospice. Results of audits will be reviewed and | |

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which is 1/2 spoonful of liquids and food. HR-A then stated that NA-M had just informed her of the SLP instructions and she had stopped feeding R19.

R19's Nutrition Risk Care Plan dated 09/08/17, indicated he received a pureed diet with honey thickened liquids and needed total assistance to the dining room and reminded of meal times. The care plan did not list specific speech therapy recommendations.

Review of R19's diet card, undated, indicated he needed total assistance to be fed and received honey thickened liquids and a pureed diet. In addition, R19's nursing assistant care sheet, undated, indicated his liquids were honey consistency and he needed total assistance with eating with a note, "see ST [speech therapy] instruction."

During interview on 10/04/17, at 12:25 p.m. licensed practical nurse (LPN)-D stated she was not aware of any feeding recommendations for R19 and stated, "What I don't know I can't tell you!"

During interview on 10/04/17, at 12:42 p.m. SLP-A stated she had written up the instructions with R19's plan of care, and had made these recommendations for R19 on 7/24/17, and trained staff that assisted with feeding him. The SLP indicated she left the feeding instructions at the table where he ate and the instructions would disappear and she would have to make new cards and leave them again at his table. SLP-A stated she also told the interim nurse manager during this time, but she no longer works at the

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shared at monthly QAPI meeting times 3 months.
Compliance of plan of correction will be completed through meal audits of all meals. Audits to include visual observation of compliance with feeding instructions, compliance with placement of feeding recommendations in binder in dining room and laminated cards placed at table, and appropriate staff assisting with feeding. Audits will be completed by DON or designee on all floors for every meal for 2 weeks and then 3 times a week for a period of 3 months to ensure compliance. Audits will be reviewed monthly at QAPI. QAPI members to determine frequency of audits after review of findings.

DON and ED responsible for compliance.

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| F 309 | Continued From page 61<br>facility. In addition, the SLP-A stated she wrote these recommendations on the 24 hour communication board for all staff to see. The SLP-A further stated R19 will cough while eating and she recommended a swallow evaluation awhile ago, but did not think the facility followed through on her recommendation. She relied heavily on the staff to follow through with her recommendations since he was at such high risk for aspiration and it was vital to follow through with SLP's recommendations. The SLP-A stated when she feed R19 1/2 teaspoons of his food and liquids he coughs much less and it reduced his risk of aspiration.<br><br>During interview 10/04/17, at 1:01 p.m. ADON-B stated, "I don't know anything about a swallow evaluation" and that she had been working on the floor at the facility for six weeks. This happened "before me and I wasn't aware of the recommendation" and reported she could call his guardian. In addition, ADON-B stated she found out about R19's recommendations last Friday when she overheard a NA instruct another NA how to feed him. ADON-B further stated R19 gets pureed food and you have to give it to him slowly and she was not aware of any portion size but to just feed him slowly.<br><br>During interview on 10/4/17, at 3:32 p.m. NA-O stated R19 had coughed a lot while eating, was slow to eat, received thickened liquids and pureed liquids. NA-O stated they use a four ounce glass to assist R19 to drink. If R19 had coughing while using the glass, he would use a spoon for the thickened liquids and give a full teaspoon of fluid. Previously (approximately 3 months ago) there were written directions on the | F 309 | | |

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table that directed staff to use a spoon for fluids but these directions were removed from the table. NA-O added staff resumed to feed R19 as did previously, either with a glass or spoon, and monitor his response. NA-O was unaware he needed to give R19 half teaspoon of fluids and not use a glass.

During interview on 10/04/17, at 3:42 p.m. NA-L stated an educator from the facility instructed her on R19's SLP-A recommendations but she stated, "I told her as soon as you walk away I won't remember what you told me. She didn't say anything and had me sign a paper saying I was educated." NA-L then stated, "I had not fed him since he was on his new diet."

During interview on 10/5/17, at 2:15 p.m. NA-Q stated she received new education and the staff needed to check the meal ticket for any special feeding instruction and directions that referred to the black book would be located on the beverage cart. A nurse needed to be in the dining room prior to staff serving resident and if anyone started coughing or choking they were to alert the nurse. Specific instructions were added to R19's meal ticket.

During interview on 10/5/17, at 2:17 p.m. LPN-F stated she had been educated on the new process regarding residents who have special diet. The ticket on table would have the instructions and if needed would indicate to check the black book which would be located on the beverage cart Nurse needed to be in the dining room prior to serving and supervise staff and assist if there were any issues with coughing or choking. Only trained staff can assist with feeding residents.

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Although R19 had a history of aspiration pneumonia, and was at high risk for aspirating, the facility failed to follow the specific SLP-A instructions to prevent aspiration, and had non-trained staff assisting R19 to eat his meal. ADON-B and NA-M were directly across the table while HR-A was feeding R19 incorrectly, and made no attempts to stop or intervene while this occurred.

A policy was requested for following SLP recommendations but none was provided.

The immediate jeopardy that began on 10/4/17, at 8:12 a.m. and removed on 10/5/17, at 2:54 p.m. when it was verified by observation, document review, and staff interview of whom could and could not feed residents, that a nurse needed to be in the dining room when residents were eating, where individual resident swallowing guidelines were located in the dining room, and what guidelines to follow to assist R19 to eat. The facility checked other resident with swallowing guidelines to ensure their programs were being followed and updated R19 careplan's along with other residents who were at risk.

R108's facility face sheet, undated, identified R108 had diagnoses of intracranial injury, psychotic disorder, paraplegia disorder, schizoaffective and bipolar disorder. R108's quarterly MDS dated 7/24/17 identified he had intact cognition, disorganized thinking, verbal altercations and physical staff assistance for activities of daily living. The behavior CAA worksheet dated 2/24/17, identified resident displayed delusions and hallucinations which could cause behaviors problems.

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During observation on 10/3/17 at 10:12 a.m. R108 was yelling in the entry way of the nursing home at (R71 and R201) stating, "Look at yourself in the mirror and you will see the definition of ugly," R71 yells back. Social Service (SS)-B whom was in the area talks to R71 who is very upset yelling (R108) calls us names all the time and nothing happens, R71 leaves the area. R201 who was in the same area, stated, "yeah" in agreement to what R71 was saying. R108 remained in area after the confrontation, looking around, no one talked with R108 about his yelling at R71. At 10:16 a.m., four minutes later, R71 was outside of the administration office yelling at executive director (ED), and assistant executive director (AED)-A, AED-B and director of quality. R71 very upset yelling, he was "tired of him [R108] yelling"' and calling him "an Indian", and (R201) a "Nigger". You have not done anything about this, and I am tired of it. All you tell (R108) to do is calm down, nothing gets done and I am sick of it. You have no idea what I or (R201) have gone through when we get called those's names. "I am sick of it!" The ED, and AED-A tried to calm R71 down. R71 kept telling administration (R108) "bums cigarettes" from (R192) all the time. I have heard him get mad at her, she doesn't like it when (R108) goes off on people, so she gives into him and he gets 3-4 cigarettes a day from her. While R71 was yelling at administration. R108 was sitting in his wheelchair approximately 15 feet away, smiling and grinning with enjoyment while watching R71 yelling at the facility administraiton staff.

R71's admission MDS identified he was cognitively intact, and needed minimal staff assistance with activities of daily living. R201 was

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just admitted to the facility on 10/2/17. There was no MDS data available as a result of R201 being in her assessment period.

During interview on 10/4/17 6:53 a.m. health unit coordinator (HUC)-B stated R108 was none compliant, and he "instigates riots here", he does this to staff and other residents. He is very demanding to other residents and staff, and wants cigarette. He tells resident's and staff that he will pay you tomorrow. HUC-B indicated if they say no to him, he swears at them using profanity which occurs several times a day. He yells, curses at everyone and bully's them when they do not do what he wants.

During observation on 10/4/17 at 7:03 a.m. R108 was sitting in the dining room with a coffee pot in front of him. He started yelling at licensed practical nurse (LPN)-H who is in the hallway approximately 50 feet away. R108 was yelling at LPN-H, "Why did you not tell him I needed my dilaudid [narcotic pain medication]," now someone else "has to do your work." He continues to yell at LPN-H about his dilaudid.

During interview on 10/4/17 at 7:10 a.m. LPN-H stated R108 was yelling for his dilaudid. If he doesn't get his coffee, pain medicaiton or cigarettes right away he has behaviors. He gets explosive and demanding, calling other residents names like, "fat flop, and Niger." LPN-H indicated no behavior plan in place, he is very demeaning to others.

During interview on 10/4/17 at 7:18 a.m. NA-A and NA-C both stated (R108) yells, swears, uses the "F word", and racial profanities telling us to go back to the country that we came from. He is

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| F 309 | Continued From page 66<br>very mean, and has a lot of behaviors. He especially yells when we want to do cares for him, reposition or toilet him. He tells us no, and when we try to calm him down he says. "I don't have to be nice, I can yell when I want." The only time that we can get him to do anything is in the early morning when he wants to get up and have a cigarette. We tell him, after we change you then you can get up and he agrees to this. When he gets what he wants, then he starts yelling again. If he knows a resident smokes he will bug that resident until he gets a cigarette. NA-A and NA-C both were unaware of any behavior plan to help deal with R108's behaviors.<br><br>During interviews on 10/4/17 at 7:30 a.m LPN-A stated R108 frequently refuses treatments, turning and repositioning along with yelling, screaming, and cursing. He calls other residents and staff, "Niger, Indian and calls the ladies bitches." He is very demeaning and tells staff I pay for you to work, so you have to listen to me. If he wants something he expects you to drop everything and do what he wants. LPN-A indicated she attempted to talk with him softly and make a plan with him, sometimes it works, other times not. He always wants his pain medicaiton sooner than scheduled. His pain medications are due at 3:00 p.m., and at 2:00 p.m. he tries to get them, but you have to stay firm with him and tell him not until 3:00 p.m. Once 3:00 p.m. comes, you need to make sure that you are there with his pain medications, then he seems to build trust with you, as long as you follow through with what you told him. This seems to work, but not all the time. If you break his trust, this will not work. There is no behavior plan the NA or nurses are following for R108, we just do our best. | F 309 | | |

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During interview on 10/4/17 at 7:47 a.m. R201 stated R108 calls me a, "Niger, bitches, hoes, fat ass, and good for nothing person." He calls me everything but a "child of god." I hate being cursed at and making me something that I am not. He hurts my feeling when R108 talks bad to me. He tries to "bum a cigarette", and I tell him "no", then he goes off, yelling at me. R201 stated this was not right that they have to put up with this and he makes me feel that I am not worth anything. When he wants something he can be all sweet until he gets what he wants, and then back to himself. Staff talk with him, but nothing changes.

During interview on 10/4/17 at 7:57 a.m. R71 stated he was coming out of the dining room the other day trying to get coffee, and R108 just yelled at him, "Hey, you fucking Indian, why are you not on the reservation." He tells me all the time that I am a, "fucking dirty Indian." I try to ignore him, and tell him "come on dude let it go," but nothing works. I just lost a (significant family member FM-A) on 9/11/17, unexpectedly. He found out about this, and at first he said he was sorry and was good. Then on Tuesday (10/3/17), I was in the dining room watching the television about the shooting in Las Vegas. R108 come up to me and asked for a cigarette, I told him "No". He tells me, I just saw you smoking one, and I know you have one, so I just ignored him. R108 then tells me, "I wonder how you dead [FM-A] is." I turned around and told him why is he like that and left the dining room, then when he was in the hallway entrance yelling, I went off on administration. Nothing changes here, staff do nothing about this, and they tell me they try, but I see nothing, and no changes to this at all.

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| F 309 | Continued From page 68<br>During interview on 10/4/17, 8:42 a.m. maintenance director (M)-A stated R108's behavior varies, he asks for coffee so I get him a pot of coffee. He calls the kitchen staff the "C word", and has burned his bridges with them. I treat him with respect, talk with him and we get along. If you do little things for him and get his respect he is better, but sometimes not. I can tell by his facial expression his mood. When he has a frown, has a glassy eyed look and staring out into space this is not a good day. SS-A used to roll him cigarettes, not sure what happened to that. R108 smokes a lot, and by the third week of the month, his behaviors get really bad because he had ran out of money. When he gets his check, his mood is better, until he spends his money.<br><br>During interview on 10/4/17, at 9:12 a.m. HUC-A stated R108's behaviors are bad, he yells at everyone and is demeaning and not nice. He used to have a behavior plan and SS-A rolled cigarettes for him. R108 would come back and get more cigarettes rolled, then sell them to other residents. The more SS-A rolled, the more cigarettes he demanded so that program did not last. As long as they (residents) give him cigarettes, he gets along with them. He tell residents he will pay them back, but he never does, resident avoid him. There is no behavior plan at all.<br><br>R108's Mood and Behavior Assessment Care Plan review on 8/8/17, identified bipolar affective disorder, and used Risperdal, Xanax and Vistaril. The interventions included, monitor for side effects, periods of altered perception or awareness, disorganized speech, lethargy, changed in cognitive level, hallucinations and | F 309 | | |

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| F 309 | Continued From page 69<br>constipation. There are no staff interventions idenfied to assist staff of how to deal with R108's behavior of being demanding, using profanity and name calling of other residents in the facility to help decrease these behaviors.<br><br>Review of the Associated Clinic of Psychology (ACP) notes from 3/31/17 to 9/29/17 identify R108 had areas of concern that increased his risk which included: compliance with medical advice, wound care, fluid restrictions, participation in therapies, medication compliance, impulse control, activity level and social isolation. The note identified R108 main focus was cigarettes. The ACP recommendations were as identified: staff need to check to make sure he is consistently taking his medicaiton, needs to follow physician recommendations, and compliant with all his cares so R108 can be successful in his recovery; R108 has agreed not to empty his colostomy bag outside; FM-B is helping R108 with the cost of his cigarettes so he has more money to purchase the cigarettes, to help reduce his behaviors. He wants his motorized wheelchair back even though R108 was unsafe using the power chair. R108's power chair has broken parts, and the facility was working on getting parts for this chair, but this is difficult since the chair model has been discontinued. A 3/31/2017 ACP note indicated that using the word "boundaries" is something that R108 knows and responds to, redirecting him by reminding him of the boundaries of his peers and staff may be helpful at times. There is no further mention of using "boundaries." A 7/21/17, and 7/28/17, note identified the writer provided R108 with validation of his feelings and emotional support as effective interventions. The 9/15/17 and 9/29/17 ACP note identified the writer used problem solving, insight | F 309 | | |

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oriented therapy, emotional support and reinforcement for positive behaviors as effective interventions.

During interview on 10/4/17 at 9:23 a.m. with ADON-A and SS-A both stated, R108 has lots of behaviors of yelling at staff and resident with very "colorful" words and has called 911 when he wanted to get out of bed and was very sick. He refuses all cares also and is a difficult person. He sees ACP on a regular basis but also refused to see them as well, he does this about once every four visits. He has only verbal behaviors and not physical, cigarettes are his main focus with his behaviors. ACP told us to develop a cigarette plan, and roll his cigarettes so his money lasted longer and this would stop him from bothering other residents. This program initially worked, but then he wanted more and more cigarettes. He started to sell them to other residents, then he complained they were not packed right and did not like the taste, so he (R108) stopped this program. This program stopped at the end of June 2017, and we have not implemented any other behavior plan since, we do our best. He uses profanity to get your attention, and if you ask him why, he says that he does this to get their attention. He is a work in progress, we try to figure out what we need to do but we do not have a plan in place for his behaviors and his behaviors have gotten worse since he was placed on 2nd floor. They try to keep him occupied but with the big staff turn over it has been tough to be consistent.

Although ACP has made some recommendations, there was no indication the facility has consistently used these recommendations or had a plan to place to

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handle or divert R108 behaviors of using profanity, yelling at residents, staff and refusing his cares.

Pain
R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact. The MDS identified diagnoses of anxiety, depression and fracture and received hospice care. The MDS identified R48 was receiving scheduled and as needed pain medication, however, did not receive any non-pharmalogical interventions related to pain. The MDS pain interview indicated R48 had pain occasionally, which made it difficult to sleep at night and limited R48's daily activities. R48 rated her pain a 7 out of 10 at the time of the MDS. R48 did not have a Pain Care Area Assessment.

During interview on 10/1/17, at 3:53 p.m. R48 stated she had pain from her belly button all the way around to her back, including her shoulders. She rated her pain 9 out of 10, with 10 being the worse pain. R48 stated she hurt like that all the time, and it went away only when she slept, if she could fall asleep. R48 did not display any signs or symptoms of pain during the interview.

R48's physician's orders signed 8/31/17, included the following pain diagnosis: chronic pain, chronically on opiate therapy, degenerative joint disease, migraines, closed fracture of the 4th and 5th metatarsal bones of the right foot and metabolic encephalopathy. The orders included the following medications used to control pain:
- morphine (narcotic for moderate to severe pain) soluble tab 5 milligrams (mg) every 4 hours PRN (as needed), started on 7/11/17.
- morphine soluble tab 5 mg every hour PRN, started on 8/4/17.

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| F 309 | Continued From page 72<br>- nitroglycerin 0.4 mg dissolve 1 tab under the tongue every 5 minutes up to 3 doses PRN, started 3/6/17.<br>- gabapentin (nerve pain) 400 mg 2 caps twice daily, started 3/6/17.<br>- morphine sulfate ER 15 mg 1 tablet every a.m. and 2 tablets in the evening every 12 hours, started 7/29/17.<br>- MPAP (acetaminophen) 500 mg 2 tabs three times daily, the order did not indicate a start date.<br><br>R48's Medication Administration Record (MAR) for October 2017, indicated the following schedule:<br>- gabapentin 400 mg 2 caps twice daily scheduled for 8:00 a.m. and 8:00 p.m.<br>- morphine sulfate ER 15 mg 1 tablet every a.m. and 2 tablets in the evening every 12 hours, scheduled for 9:00 a.m. and 9:00 p.m.<br>- MPAP (acetaminophen) 500 mg 2 tabs three times daily, scheduled for 8:00 a.m., 12:00 p.m. and 8:00 p.m.<br><br>R48's facility medical record lacked a comprehensive pain assessment and a care plan directed towards pain.<br><br>On 10/3/17, at 9:37 a.m. R48 was observed seated in her wheelchair in her bedroom. R48 did not display and signs or symptoms of pain, but had a flat affect. R48 stated she had scheduled pain medication for 8:00 a.m. and had not received her medications yet. R48 stated hospice has communicated to the facility it was important to receive the pain medication timely. She stated the floor nurse told her she was running behind on her medication pass this morning. R48 stated she rarely asked for her PRN pain medication as | F 309 | | |

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it took staff so long to bring it, she just tries to sleep away the pain. R48 again rated her pain a 9 out of 10.

On 10/3/17, at 10:19 a.m. RN-E administered R48's morning medications by bringing them to her room.

During interview on 10/3/17, at 10:20 a.m. RN-E stated she had a "hectic" morning pre- packaging residents' medications to take on leave from the facility and was just administering R48's morning medication. RN-E stated the medications were scheduled for 9:00 a.m. RN-E stated the staff have an hour before and an hour after the scheduled medication times to administer medication. At 10:22 a.m. RN-A approached RN-E's medication cart. RN-E stated she was just administering R48's morning medications, that included pain medications. RN-A then stated, "that's not good." At 10:48 a.m. RN-E stated she administered R48 the following medications after the scheduled time: omeprazole (treatment of gastroesophageal reflux disease) 40 mg, ativan (anti-anxiety) 0.5 mg, morphine sulfate (narcotic) 15 mg, two tablets of Tylenol (pain reliever) 500 mg, two capsules of diltiazem (treat high blood pressure, angina and certain heart rhythm disorders) 180 mg, duloxetine (treat major depressive disorder, ) 60 mg, and two capsules of gabapentin (treat nerve pain) 400 mg.

During interview on 10/3/17, at 11:46 a.m. NA-C stated R48 had never complained of pain to her, but if she did NA-C would notify the nurse. NA-C further stated the nursing assistants did not interact much with R48 as she was independent with most cares.

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During follow up interview on 10/3/17, at 2:06 p.m. R48 stated her pain was "pretty bad" right now, and after receiving her pain medications late, it didn't help her pain much. R48 stated she was going to lie down and try to sleep to relieve her pain.

On 10/3/17, at 2:35 p.m. RN-E stated R48 was asked her pain level at least every shift, occasionally she requested PRN pain medication, and usually rated her pain a 7 out of 10 or better. RN-E stated she thought the medications helped her and stated going to chapel was a non-pharmalogical intervention. RN-E stated a comprehensive pain assessment was done on admission, but was not sure if the pain assessments were completed any other time.

During interview on 10/5/17, at 9:12 a.m. ADON-C stated it was important to receive pain medications timely, because it is hard to get pain under control, and when it gets out of control R48 becomes more anxious increasing the pain.

When interviewed on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain, or had changes to her pain medications within the last few months. ADON-A reviewed R48's chart and stated there should be a comprehensive pain assessment and care plan to help manage R48's pain.

During telephone interview on 10/5/17, at 11:25 a.m. hospice RN-F stated he had communicated to the floor nurse on how giving pain medications timely was very important for R48. RN-F stated it was important not only to control her pain, but for her psychosocial well being as she gets very

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anxious which increased her pain levels.

HOSPICE

R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had an indwelling urinary catheter. R134's care plan dated 10/17, indicated he had a history of urinary tract infections and had a Foley catheter. R134's Urinary Incontinence Care Area Assessment (CAA) dated 7/27/17, indicated he needed total dependence with toileting and was incontinent of bowel and bladder and staff managed all incontinence cares and used incontinent products. The CAA assessment indicated he had urinary urgency and needed assistance with toileting. The CAA failed to indicate he had a catheter.

R134's hospice care plan dated 07/07/17, indicated R134 had alteration in bladder elimination and had an indwelling urinary catheter. Home health/hospice was to assess bladder function, hydration and education on urinary catheter care as needed. In addition the hospice care plan indicated patient, family, caregiver will demonstrate proper catheter care.

On 10/03/17, at 8:22 a.m. R134 was observed in the dining room to have a catheter bag attached below his Broda chair (tilt and space positioning chair).

During interview 10/03/17, at 9:30 a.m. hospice nurse-North Memorial (HN)-A stated R134 had been put on their case load on 07/06/17, and he

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has had his catheter ever since he was admitted to hospice. In addition, HN-A stated hospice had not changed his catheter, tubing or bag and that was the facility's responsibility.

During interview on 10/05/17, at 8:43 a.m. assistant director of nursing (ADON)-B stated R134 had went to the hospital in July 2017, when he was on third floor and transferred to first floor when he returned from the hospital. ADON-B stated his catheter bag should be changed weekly and the catheter should be changed monthly. ADON-B stated there no orders when he returned from the hospital for catheter care and she was not sure if either had been completed since they had no orders. The ADON-B stated the facility should be responsible for his catheter cares.

During observation 10/05/17, at 8:59 a.m. R134 was observed in bed. His indwelling catheter was observed attached to the left side of the bed. The catheter anti-reflux valve and tubing inside was covered in a thick, mucus gray matter.

During interview on 10/05/17, at 9:00 a.m. NA-J stated he did not normally see gray sediment on a catheter. He indicated R134 had been in the hospital and returned to the first floor with the catheter. NA-J stated staff empty the catheter bag each shift.

During interview on 10/05/17, at 9:11 a.m. ADON-B stated the facility should have orders on when to change the catheter, bag and tubing and indicated she was unable to locate orders for R134. ADON-B stated she would assume staff had not changed the catheter, tubing and bag since he returned from the hospital on 07/05/17,

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| F 309 | Continued From page 77<br>(almost two months). ADON-B further stated she noticed the sediment in the catheter and did not know why he had a catheter since he never had one before his hospitalization. ADON-B stated the catheter was placed in the hospital on 6/23/17, and the record did not indicate the reason for the catheter.<br><br>During interview on 10/05/17, ADON-B stated she had contacted R134's physician and received orders to remove the catheter since the facility did not have a reason for R134 to have the catheter. ADON-B further indicated she had taken his vital signs and his temperature was 98.2 and had no signs of sepsis.<br><br>Although R134 had an indwelling catheter, neither hospice or the nursing home had coordinated his care to identify whom was responsible for care of the catheter for R134.<br><br>A Service Agreement By And Between Hospice And A Nursing Facility (North Memorial Hospice), dated 05/23/16, indicated: "Combined Plan of Care means a written care plan established, maintained, reviewed, and modified, in collaboration between Hospice and the Nursing Facility that includes (a) an assessment of each patients needs, (b) an identification of Hospice Services, including management of discomfort and symptom relief needed to meet such patient's need and related needs of the Hospice Patient's Family, and (c) details concerning the scope and frequency of such Hospice Services. (d) delineation of accountability of services".<br><br>R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact. The MDS identified | F 309 | | |

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diagnoses of anxiety, depression and received hospice care. The MDS identified R48 was receiving scheduled and as needed pain medication, however, did not receive any non-pharmalogical interventions related to pain. The MDS pain interview indicated R48 had pain occasionally, which made it difficult to sleep at night and limited R48's daily activities. R48 rated her pain a 7 out of 10 at the time of the MDS. R48 did not have a Pain Care Area Assessment.

R48's facility medical record lacked a comprehensive pain assessment and care and a care plan directed towards pain. R48's Palliative care plan dated 8/17, indicated R48 was receiving end of life care related to coronary artery disease and congestive heart failure. The care plan indicated physical symptoms of pain and declining status. Hospice and nursing staff were responsible for disease management. Interventions included: support choices and convey theses choices to attending and consulting physicians and clinical sources as needed, liberalize diet according to medical condition, encourage fluids unless contraindicated and per resident comfort level, support resident's decision not to eat or drink, and see pain management care plan. There was no facility pain management care plan.

R48's hospice documentation was kept in a separate binder at the nursing desk, and included hospice changes in the hospice care plan and orders. The most recent Hospice IDG Comprehensive Assessment and Plan of Care Update Report was dated 6/15/17. Hospice start of care was on 3/9/17, and was currently recertified for hospice care from 6/7/17, to 9/4/17. A current problem list included altered comfort.

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Pain remained a 7, 8, or 9 out of 10 with little change after collaboration with resident and facility nurse, discontinued short acting morphine and increased long acting MS Contin to 30 mg at bedtime.

During interview on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain and any pain medication changes in the last few months. ADON-A stated the most recent hospice care plan was from July 2017. ADON-A stated the hospice nurse may check in with the floor staff, but the ADON's who managed the care in facility were not getting notified in changes in the hospice care plan to effectively coordinate the needed care. ADON-A stated the communication between the facility and hospice was poor. ADON-A stated she had never been invited to attended a care conference with R48 and her hospice team.

During telephone interview on 10/5/17, at 11:25 a.m. from AserCare Hospice RN-F stated the communications between hospice and the facility was going okay. RN-F further stated there has only been one care conference between hospice and the facility since the start of care in March. RN-F stated there were no facility nursing staff present and only the social services assistant (SS)-A and R48's spiritual advisor were present at the care conference. RN-F stated hospice reviewed their resident care plans every two weeks and the company was to fax over the updated forms when completed. RN-F was not sure why the facility's most recent hospice care plan was from July 2017, and there needed to be better coordination of care.

The Hospice Care Services Agreement between

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| F 309 | Continued From page 80<br>the facility and AserCare Hospice set to expire on 11/10/17, indicated: "The facility shall furnish 24 hour room and board care, meeting the personal care and nursing needs of the Hospice Patient in coordination with the Hospice representative and ensure that the level of care provided is what would have been provided by the primary caregiver at home and at the same level of care provided before Hospice care was elected." | F 309 | | |
| F 312<br>SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure residents were assisted with personal hygiene for 3 of 5 residents (R55, R2, R183) reviewed for activities of daily living (ADL) and who were dependent on staff for care.<br><br>Findings include:<br><br>R55's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine, with moisture associated skin damage. Diagnoses included dementia and depression. | F 312 | R55, R2, and R183 will receive assistance with activities of daily living as needed per plan of care to maintain good grooming and personal hygiene and to be free of odors.<br><br>Residents that reside in the facility have the potential to be affected and will receive assistance per the plan of care to maintain good personal hygiene and be free of odors.<br><br>Licensed nurses and NARs will be re-educated on following the plan of care and providing assistance with ADLs for residents who are unable to complete independently. Education will also be provided regarding incontinence care and following toileting plans per the plan of care. | 11/13/17 |

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| F 312 | Continued From page 81 R55's ADL/Mobility care plan last dated 4/10/17, included a goal for R55 to be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene and dressing.<br><br>On 10/1/17, at 9:50 a.m. R55 was seated in her wheelchair in the doorway to her room. A dark brown substance was noted to be under her long fingernails on her right hand.<br><br>During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap. During this time R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting with her. At 11:18 a.m. the social services director (SSD) brought R55 onto the elevator to bring her for a cigarette. SSD did not address R55's urinary incontinence.<br><br>During subsequent observation on 10/3/17, at 9:58 p.m. R55 continued to have a dark brown substance under her long fingernails on her right hand. At this time registered nurse (RN)-A bent down next to R55 and asked her how she was. R55 stated she was fine and RN-A continued to the elevator.<br><br>On 10/3/17, at 11:43 p.m. R55 was seating in her wheelchair in the dining room. R55 used her right hand, which continued to have a dark brown substance under her fingernails, and picked a potato out of her potato salad and placed it in her mouth. At 1:52 p.m. nursing assistants (NA)-C and NA-R transferred R55 to her bed. Neither NA-C or NA-R offered to clean R55's fingernails. NA-C stated nail care was done on residents' bath days by the nursing assistants unless they | F 312 | Nurse managers and DON will complete personal care audits on each unit. 3 residents will be audited weekly for 4 weeks then monthly times 2 months. Results of the audits will be forwarded to the QAPI committee for opportunities of continued quality improvement X 3 months.<br><br>DON to monitor compliance. | |

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were diabetic, then the nurse did the nail care.

On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.

R55's bath list indicated she received showers on Tuesday evening (which would have been 10/3/17).

During observation on 10/4/17, at 7:08 a.m. assistant executive director (AED)-B assisted R55 outside to smoke. R55 held her cigarette in her right hand and AED-B lit her cigarette. AED-B never offered to have R55's nails cleaned and brought her back upstairs to the 4th floor dining room for breakfast.

During observation on 10/4/17, at 8:07 a.m. NA-H brought R55 out of the dining room back to R55's room and started cleaning her fingernails. NA-H stated her nails were "really really dirty" and they should be cleaned every day. NA-H stated she noticed they were dirty when she got her up this morning, however, someone brought her out to smoke before she had a chance to clean them. NA-H stated nail care should be done as needed and on their bath days. NA-H confirmed R55 was scheduled for a shower the evening before and nail care should have been done.

During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)-A stated nail care should be done daily with cares if visibly dirty, otherwise weekly with their showers. ADON-A stated resident should not be sitting in urine soiled clothing.

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R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R2 was frequently incontinent of urine, with moisture associated skin damage. Diagnosis included was schizophrenia. R2's ADL Care Area Assessment (CAA) dated 8/19/17, indicated R2 was at risk of a functional decline due to psychoactive medications, physical limitations, falls, complications of mobility including incontinence, weight loss and depression. A care plan was to be developed to slow or minimize a decline, avoid complications and minimize risks. The CAA directed to see care plans for problems, goals and interventions.

R2's ADL/Mobility last reviewed on 8/5/17, indicated R2 would be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADLs and at times refused shaving. The care plan lacked approaches to refusal of cares.

During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweatpants were saturated with urine in the front and back, as well as the right lower side of his shirt. R2's hair was uncombed and sticking up in multiple places. Multiple staff were located around the nursing desk and no one offered to take him back to his room to assist with changing his clothes and combing his hair. At 3:00 p.m. R2 was observed

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lying on his right side in bed, the back of his pants were saturated with urine. R2's room had a strong odor of urine present that could be smelled in the hallway.

On 10/3/17, at 10:12 a.m. R2 was walking in the hallway in front of the nursing desk, his shoes were untied, his hair was uncombed and sticking up in multiple places, his gray t-shirt had a tear in the back of the collar from one side of the neck to the other. ADON-A approached R2 and offered to tie his shoes. R2 allowed ADON-A to tie his shoes, however ADON-A did not offer to take him back to his room and help him change his shirt or comb his hair.

On 10/4/17, at 6:51 a.m. R2 was sitting in the dining room watching television. His hair was uncombed and was sticking up in multiple places. His gray t-shirt had a quarter sized hole in the front. R2 was in the dining room until 9:06 a.m. when he walked down the hall towards his room and laid in bed. Staff did not approach R2 and offer to change his shirt or comb his hair, during this time.

During interview on 10/4/17, at 8:47 a.m. social services assistant (SS)-A stated R2 had a brother that he had contacted in the past about getting new shoes and the brother bought him a new pair. SS-A stated he had not noticed the holes in R2's clothing and had not notified R2's brother for help in obtaining new clothing. SS-A stated it was a residents right to wear what they wanted, however, R2 would never complain about having holes in his clothing unless they were really large.

During interview on 10/4/17, at 9:12 a.m. NA-G

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stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are aware when R2 was soiled, and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and was not sure who did. NA-G stated he was fairly independent but needed hands on assistance frequently and did allow staff to comb his hair and assist with changing his clothes, it just depended on how staff approached him.

R2's Behavior Detail Report from 7/7/17 to 10/4/17, indicated R2 resisted care one time on 9/16/17, and staff was able to redirect R2.

During interview on 10/5/17, at 9:39 a.m. ADON-A stated in the past R2 had done some of his own personal cares, however, staff should be offering assistance as needed. Although, R2 is to be offered toileting and assistance every two hours, staff should have assisted him with changing his clothing soiled with urine. Any refusals needed to be charted and reported to a nurse so others could try and assist with needed cares. ADON-A stated a lot of residents have holes in there clothes and have no one to buy them any. She was aware R2 had clothing with holes, however, did not recall if she communicated R2's need to social services for assistance. Staff should be helping R2 with combing his hair. ADON-A also stated R2's care plan needed to be looked at further for accuracy.

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R183's Admission Record, dated 10/5/17, identified multiple medical diagnoses including heart failure, diabetes, morbid obesity, hypertension, lymphedema, chronic respiratory failure and urinary retention.

R183's admission MDS dated 8/3/17, identified R183 had intact cognition with moderate symptoms of depression. R183 required extensive assistance to complete all ADL's except eating, had an indwelling catheter and did not ambulate.

A review of R183's care plan dated 7/28/17, identified R183 required personal assistance with personal hygiene/grooming/dressing/undressing. R183's care plan did not list interventions to use to maintain R183's hygiene and meet his bathing needs.

On 10/1/17, at 3:44 p.m. R183 was noted to be resting on his bed, covered only with a sheet. R183 was noted to have a strong, pungent odor of perspiration and other body odors. A straight urinary drainage bag was noted attached to the bed frame, and tubing from the bag was observed under the sheet. R183 stated he was dependent on staff for provision of care stating, " I can turn my light on, but I don't know how long it will take them to come." R183 did acknowledged he had called 911 when he had been left on the commode for 45 minutes. He stated the staff responded within five minutes after he called. R183 stated his bath is scheduled for Mondays, but had not yet received one since admission to the facility greater than two months ago. R183 stated to receive a shower he would need to be

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transported on a gurney and assisted to shower while on the cart. R183 stated he has received "A whore bath," when he was assisted to wash up with a basin.

During interview on 10/2/17, at 12:23 p.m. R183 stated he was going to get dressed today but did not feel real clean. R183 stated his last bed bath was about two weeks ago. R183 was noted to be dressed in a hospital gown at this time and was noted to have an increase of strong, pungent body odor that had been noted on 10/1/17. The strong, pungent body odor was very prominent in the room, and also notable in the hallway outside of the R183's room. R183 stated he chose not to get up for lunch, and stated it would take too long to get back to bed, would become uncomfortable and had a history of pressure ulcers. Following interview, the bath schedule was noted to be posted at nurses station and identified R183 received his bath on Tuesday evenings.

During interview on 10/4/17, at 7:05 a.m. R183 stated he had received a bed bath last evening. R183 stated after his bed bath he requested to get up out of bed and was asked why he wished to get up. R183 stated he had to instruct staff to change linens following his bath as he wished to have fresh linens. R183 stated his linens were changed as requested.

During interview on 10/4/17, at 2:19 p.m. nursing assistant (NA)-S stated he had provided assistance for a bed bath for R183 and stated he felt he had provided care according to R183's care plan. NA-S stated the resident can also identify what they want. NA-S stated he had performed catheter hygiene for R183.

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A review of R183's physician progress notes of 10/2/17, identified R183 did not wish to pursue catheter removal noting, "I can't even get someone here to help me shit. I won't be demeaned any further."

During interview on 10/5/17, at 9:59 a.m. the ADON-B stated R183 was very impatient and went on to state if he does not receive immediate assistance, he will attempt to self transfer, or call 911. ADON-B stated the call light should be answered immediately, with assistance provided within ten minutes, however, it may take longer to summon adequate staff to provide assist of two for transfers. ADON-B stated she was unaware of concerns regarding personal odors, and expressed it was the expectation residents were washed up with morning and bedtime cares, including washing of face, hands, pericare, armpits, and application of lotion and deodorant. ADON-B stated residents hair are routinely washed on bath day.

Review of R183's resident care tracker from 9/28/17 through 10/3/17, was done with ADON-B. The resident care tracker had notations made R183 had received two bedbaths in one day at times. ADON-B stated he would not of gotten two bedbaths in a day and felt the documentation had been completed incorrectly. ADON-B indicated she was not aware if R183 had received a shower, but stated if short staff and unable to complete the shower, the task would be passed on to the oncoming shift to complete. The ADON-B stated it would be appropriate for him to be washed up and receive a bath at the time the odor was noted.

A request for provision of bathing process was

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| F 312 | Continued From page 89<br>also requested and not provided.<br><br>The facility policy Activities of Daily Living (ADL) Program dated 7/15, included: "Determine if the resident has specific tasks and areas requiring ADL assistance. Bathing, dressing and grooming techniques and interventions may include, but are not limited to:"<br>· Selecting and obtaining clothes<br>· Putting clothes on<br>· Fastening buttons and snaps<br>· Taking off all items of clothing<br>· Applying or removing braces and artificial limbs<br>· Use of adaptive equipment<br>· Maintaining personal hygiene<br>· Planning the task<br>· Gathering supplies<br>· Combing hair<br>· Washing face and hands<br>· Brushing teeth<br>· Shaving if applicable<br>· Applying deodorant<br>· Applying make-up if applicable<br>· Trimming nails<br>· Use of adaptive equipment | F 312 | | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure | F 314 | | 11/13/17 |

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| F 314 | Continued From page 90<br>ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely repositioning for 2 of 4 residents (R121, R134) whom had or were identified at risk for pressure ulcer development. In addition the facilty did not provide a comprehensive assessment for 1 of 2 residents (R6) in the sample with a stage three pressure ulcer.<br><br>Findings include:<br><br>TURNING / REPOSITIONING<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent and required the physical assistance of two staff for bed mobility, and toileting. The MDS indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue). The care area assessment (CAA) worksheet for pressure ulcers, dated 8/21/17, also identified R121's total dependence upon staff for bed mobility. The CAA indicated R121 was incontinent of bowel and bladder, was unable to communicate needs and did not speak,further staff anticipated R121's needs. The CAA also | F 314 | R121, R134, and R6 will receive the necessary care and monitoring to promote healing and prevent new ulcers. Physician will be updated if wounds are assessed to not be healing or wound is getting worse. Identified residents will be repositioned per plan of care. PUSH tools will be completed weekly per policy for pressure ulcers to monitor status of wound. R6 had a reassessment of skin risk factors, PUSH tool updated, and plan of care reviewed for accuracy.<br><br>Residents that reside in the facility with a pressure ulcer or those who are at risk for pressure ulcers have the potential to be affected. Residents with current pressure ulcers will have a comprehensive skin assessment completed; PUSH tool completed as applicable; and care plans updated with new assessment.<br><br>Licensed nurses and NARs will be re-educated on policy regarding pressure ulcer prevention and treatment. Licensed nurses will be re-educated on policy for monitoring pressure ulcers including the use of the PUSH tool. | |

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indicated R121 had a stage 4 area to coccyx, and was seen by a wound doctor weekly.

During observation of R121's dressing change on 10/2/17, at 12:34 p.m., R121's wound was observed. R121's wound was open, on the coccyx area, and measured approximately 4 centimeters (cm) by 2.5 cm with depth of 1.25 cm. The wound bed was dark pink in color. The surrounding skin was intact, normal in color, and free of maceration or swelling. The wound was without odor, and had minimal drainage.

During continuous observation on 10/3/17, from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed which remained unchanged. At 1:58 p.m., nursing assistants (NA)-D and NA-B entered R121's room, closed the door behind them, and announced to R121 they were going to "check you" and "reposition you." Working on each side of R121's bed, NA-D and NA-B raised the bed to a working height, and began their cares, talking with R12. R121's brief was checked and was not wet. NA-B removed the pillow from under R121's left side, and NA-D took out the pillow between his legs. Together NA-B and NA-D pulled R121 up in bed, then refitted the pillows between his legs, and then placed R121 slightly facing the window, with a pillow under R121 right back side. The pillow between R121 legs was replaced, and legs adjusted, then R121 was covered with the bed sheet. Before NA-B and NA-D exited the room, they removed gloves and washed their hands.

During an interview on 10/3/17, at 2:06 p.m., nursing assistant (NA)-D stated the last time R121 was "done" (repositioned) was at 11:30, and now it was two o'clock. NA-D stated we got

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DON or designee will complete turning and repositioning audits on each unit. Each unit will audit 3 residents weekly for 4 weeks then monthly times 2 months. DON or designee will audit wound book for presence of PUSH tools in place. Wound book will be audited weekly for 4 weeks then monthly times 2 months. Results of the audits will be forwarded to the QAPI committee for opportunities of continued quality improvement for 3 months.

DON to monitor compliance.

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busy, and that (R121) should be checked and turned every two hours. NA-D stated "it was late."

The "Skin Integrity Assessment: Prevention and Treatment Care Plan" for R121, dated 4/17, identified R 121's pressure ulcer to coccyx, and directed a turn and reposition program with a frequency of "Q2" (every) two hours. The care plan also directed staff to monitor wound weekly and PRN (as needed).

Review of Wound Care Specialist Evaluations:
--Initial Evaluation, dated 4/26/17, indicated R121 has wound on coccyx. Wound size (L x W X D) (length, by width by height): 2 x 0.5 x no measurable cm (centimeters). 100% granulation tissue. At request provider, R121 presents with a stage 3 pressure ulcer wound Coccyx of a least 1 day duration. There is no exudate (drainage). There is no indication of pain associated with this condition. Wound size 1.0 Under assessment and Plan of Care Recommendations: stage pressure ulcer wound -coccyx-initial evaluation. Discontinue house barrier cream twice daily; add skin Prep once daily, foam, once daily; group 2 mattress (pressure reducing), vitamin C 500 mg twice daily, zinc sulphate 220 mg once tail for 14 days, off load wound, reposition per facility protocol. Factors complicating wound healing: anemia.

--evaluation dated 5/24/17: Pressure wound,;stage 4; duration greater than 27 days; wound size 6.5 cm x 7 x 0.3 cm; light ser-sanguinous exudate; 15% thick adherent devitalized necrotic (dead, scar) tissue; 40% granulation (new growth) tissue; 45% skin; wound progress: deteriorated. Assessment and

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Plan of Care recommendations: surgical excisional debridement; continue skin prep once daily; foam once daily; Santyl once daily.

--evaluation dated 6/14/17: Pressure wound stage 4; duration greater than 26 days; wound size: 6.2 x 3 x 0.3 cm; light sero-sanguinous exudate; 100% thick adherent devitalized necrotic tissue; wound progress: deteriorated. Assessment and Plan of care recommendations: surgical excisional debridement; continue skin prep, foam and Santyl once daily.

--evaluation dated 6/21/17: pressure wound, stage 4, greater than 53 days; wound size 4.5 x 3 x 2.3 cm; light sero sanguinous exudate; 75% thick adherent devitalized necrotic tissue; 25% granulation tissue; wound progress improved. Assessment and Plan of Care Recommendations: surgical excisional debridement. Discontinue skin prep once daily; foam once daily; Santyl once daily; add negative pressure three time per week, skin prep to peri wound are.. three time per week.

--evaluation 6/28/17: pressure wound stage 4, greater than 50 days in duration; sound size 4 x 4 x 1.8 cm; peri wound (area around wound): odor surrounding DTI (deep tissue injury) (purple/Maroon) maceration; moderate Sero -sanguinous exudate; wound progress deteriorated. Assessment and Plan of Care Recommendations: surgical excisional debridement; continue negative pressure three times per week; skin prep to periwound area three times per week.

--evaluation 7/5/17: pressure wound stage 4, greater than 66 days in duration; wound size:

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| F 314 | Continued From page 94<br>5.2 x 4.8 x 2.4 cm; periwound radius odor; undermining (tunneling under skin) 4 cm at 3 o'clock (position on wound); moderate Sero-sanguinous exudate; 60% thick adherent devitalized necrotic tissue; 40% granulation tissue; wound progress improved. Assessment and Plan of Care Recommendations: surgical excisional debridement; negative pressure three times per week; skin prep to periwound area, three times per week. Prealbumin recommended on 7/5/17<br><br>--evaluation 8/9/17: pressure wound stage 4, greater than 99 days; wound size 4.4 x 4 x 3.8 cm; light Sero sanguinous exudate; 100% granulation tissue; wound progress improved. Assessment and Plan of Care Recommendations: improved as evidences by decreased surface area, increased granulation , continue: protective dressing, twice daily, wet to moist, twice daily.<br><br>Review of recent Wound Assessment Skin Grid, for R121 indicated the following:<br>--9/27/16 stage 4 pressure ulcer (PU) measuring 4.1 cm (centimeters) in length, x (by) 2.8 cm in width, x 1.3 cm in depth; no drainage from the wound; red in color and had tunneling (open areas under the wound) at 12 o'clock (location on the wound); no blood noted, area is painful to touch.<br>--9/20/17: stage 4 PU; 4 x 3.2 x 2.0 cm, bloody drainage, necrotic (dead tissue) slough and mild odor; undermining at 12 o ' clock; debrided by doctor, d/t (due to) necrotic tissues, wound deeper and mild odor; air mattress frequently at wrong setting, education done with staff by writer.<br>--9/11/17..stage 4 PU; 3.6 x 3.0 x 1.0 cm; serosanguineous drainage, red in color, no odor, | F 314 | | |

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| F 314 | Continued From page 95<br>tunneling 3 to 8 o'clock.<br>---9/6/17 stage 4 PU; 3.8 x 3.0 x 1.3 cm; sero-sanguineous drainage, red in color, no odor, and tunneling 3 to 8 o ' clock.<br>--8/30/17 No weekly skin grid assessment found<br>---8/23/17 No skin grid assessment found<br>---8/17/17 stage 4 PU, 3.8 x 3.6 x 2.5; sero sanguineous pink drainage; no odor and tunneling/undermining 3.8 cm depth at 12 o'clock<br>---8/9/17 no weekly skin grid assessment<br>---8/2/17 no weekly skin grid assessment<br>---7/26/16 no weekly skin grid assessment<br>---7/19/17 no weekly skin grid assessment<br>---7/12/17 no stage PU listed; 5.0 x 4.0 x 3.0; serosanguinous drainage with necrotic/slough tissue 40%; no odor; tunnel/undermining at 2 o'clock with depth 4.5 cm.<br>---7/5/17 no stage PU listed; 5.2 x 4.8 x 2.5 cm; serosanguinous drainage; necrotic/slough 60%; mild odor; tunneling/undermining at 4 o ' clock with depth of 4 cm.<br>---6/28/17 no stage PU listed; 4.0 x 4.0 x 1.8 cm; serosanguinous drainage; red in color; foul odor; no undermining/tunneling identified<br>---6/21/17 no stage listed; 4.5 x 3.0 x 2.3 cm; serosanguinous drainage; no odor; no tunneling/undermining identified<br>---6/14/17 no stage PU listed; 6.2 x 3.0 x 0.3; serosanguinous drainage; 100% necrotic tissue; no odor; no tunneling/undermining identified<br>---5/31/17 no stage PU listed; 6.5 x 2.5 x 1.2 cm; serosanguinous drainage; necrotic tissue; no odor, no tunneling/undermining identified<br>--5/24//17 no PU stage listed; 6.5 x 7 x 3.0 cm; serosanguinous drainage; necrotic tissue; no odor; no undermining/tunneling<br>---5/17/17 no PU stage listed; 6.0 x 2.3 x 0.1; serosanguinous drainage; necrotic tissue present; no odor; no undermining or tunneling | F 314 | | |

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| F 314 | Continued From page 96<br>---5/10/17 no PU stage listed; 2.1 x 0.6 x 0.1; serosanguinous drainage; pink tissue noted; no odor; no tunneling or undermining<br>---5/3/17 no PU stage listed; 2.3 x 0.6 x 0.1; no drainage; pink tissue noted; no odor; no tunneling or undermining<br>---4/26/17 no PU stage listed; 2.0 x 0.5 x 0 cm; no depth, no drainage, no color; no odor; no undermining/tunneling<br>---4/19/17 no PU stage listed; 3.5 x 4 cm no depth; no color; no drainage; no odor; no tunneling /undermining<br>---4/12/17 (onset); indicated no present upon admission; site is coccyx; 0.2 x 0.2 and 0.1 cm; no drainage, no color, no odor; no undermining<br><br>During interview on 10/2/17, at 6:14 p.m., family member (FM)-A stated she was aware of R121's "bed sore" and stated she had concerns that he was not getting repositioned off his bottom timely. FM-C stated there were frequently times when she was at the facility when R121 was left "for three hours" before he was turned. FM-C stated she told the aides "he's supposed to be (repositioned) every two hours." FM-C stated due to the wound, staff need to make sure [R121] stays as dry as possible." FM-C stated she did not think R121's repositioning always got done right. FM-C stated there was an issue with "staffing," no consistency, with so many new people always working. FM-C stated she had told staff they have to treat (R121) "like you'd treat family."<br><br>When interviewed on 10/3/17, at 4:30 p.m., registered nurse (RN)-B stated it was his expectation that residents be turned "timely" so that the wound could be taken care of and not break down more. RN-B stated R121 had a | F 314 | | |

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open, stage 4 pressure ulcer, and also it was "not acceptable" that R121 was not turned as he was supposed to be. RN-B stated he thought some of the aides needed more training and needed to be more aware of the residents' care needs.

During interview on 10/4/17, at 11:22 a.m., medical doctor (MD)-B, a provider for R121, stated the pressure ulcer was at stage 4, and was not deteriorating, but the wound was stable. MD-B stated "98%" of R121's wound improvement and success would be due to nursing, and the aides need to have him "turned and repositioned timely." MD-B stated the current orders included twice daily cleansing of the wound, and wet to moist dressing with Dakins solution, which is an great antiseptic, and crushed Flagyl right into the wound.

When interviewed on 10/4/17, at 8:52 a.m., the assistant director of nursing (ADON)-C stated R121 had a current stage 4 pressure ulcer, and also skin and wound assessments were to be completed by licensed staff at least weekly, and would expect the assessments be documented at least weekly. ADON-C stated she exoected R121 to be turned and repositioned every 2 hours as care planned.

R134's significant change Minimum Data Set (MDS) dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with bed mobility, transfers and toileting. The MDS further indicated he was at risk for pressure ulcers and had no pressure ulcers. R134's Care Area Assessment (CAA) dated 07/27/17, indicated he was dependent on staff for activities of daily living (ADLs) and is repositioned per staff

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| F 314 | Continued From page 98<br>and transfers with assist of two and mechanical lift. The CAA futher indicated he used a wheelchair with a cushioned seat and was incontinent of bowel and had an urinary catheter. In addition, the CAA indicated he was at risk for pressure and required staff assistance to move sufficiently to relieve pressure over any one site and required regular schedule of turning.<br><br>R134's Skin Integrity Assessment: Prevention And nutrition, friction and shear. The care plan further indicated he was to be repositioned every two hours and to provideTreatment Plan Of Care dated 10/03/17, indicated he required frequent turning, protect heels and manage moisture, a pressure relief surface. In addition, the care plan indicated he was always incontinent of bowel movement (BM) will have decreased episodes of incontinence by a established elimination schedule and will be cooperative with assisted toileting. 32 minutes) R134 was observed to be sitting in his Broda chair (tilt and recline positioning chair), without being repositioned/toileted or check and change. At 8:35 a.m. R134 was observed across from the nurses station on the first floor, at 9:00 a.m. R134 was moved across from the nurse's station in the hall, at 9:12 a.m. R134 was asleep in the Broda chair, at 9:30 a.m. registered nurse (RN)-K/ hospice nurse moved R134 from the hall to the dinning room. At 10:02 a.m. RN-K moved R134 back into the hall across from the nurse's station. At 10:22 a.m. R134 was asleep in the hall in his Broda chair. At 10:42 a.m. R134 was still in hallway in chair asleep. At 11:00 a.m.<br><br>During continuous observation 10/03/17, from 8:35 a.m. to 11:07 a.m. (2 hours and he was still asleep. At 11:07 a.m. surveyor informed nursing | F 314 | | |

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| F 314 | Continued From page 99<br>assistant (NA)-M and NA-J of findings.<br><br>During interview 10/03/17, at 11:01 a.m. NA-N stated that he had repositioned and checked him for incontinence right after breakfast around 8:30 a.m..<br><br>During interview 10/03/17, at 11:12 a.m. NA-M stated she had assisted NA-N right after breakfast with repositioning R134. She indicated did not have a chance to reposition him again because they do not have enough staff and that he needed assist of two so she could not reposition him timely.<br><br>During observation 10/03/17, at 11:30 a.m. (almost 3 hours without repositioning) NA-J and NA-N were observed to reposition and check R134. R134 was continent of bowel and had a catheter for urine. In addition, R134's skin was intact with no open areas or redness of the skin.<br><br>A Procedure Turning and Positioning, effective July 2015 indicated: "The center provides assistance with turning and positioning. Residents will be turned and positioned according to their co-morbidities and individual abilities. The center strives to avoid musculoskeletal injury and fatigue and reduce the risk of injury of residents with the use of positioning techniques. The center strives to prevent pressure ulcers with turning and repositioning. Turning and repositiong may prevent pooling of lung secretions and improve circulation."<br><br>Although R134 was assessed to be at risk for pressure ulcers and was care planned to be turned and repositioned every two hours, R134 went almost three hours without being | F 314 | | |

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repositioned to help prevent development of pressure ulcers.

A facility policy, Pressure Ulcer Prevention/Treatment, dated July 2015, indicated all residents would be assessed upon admission and at regular intervals. Further, the policy identified interventions to manage pressure, including the use of turning and repositioning, and also directed to review and revise the skin integrity assessment to reflect interventions to heal pressure ulcers and stabilize, reduce or remove underlying risk factors.

LACK OF ASSESSMENT:

R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs), had unhealed pressure ulcers and remained at risk for further pressure ulcer development. Further, the MDS identified R6 had rejection of care(s) on a regular basis, "but less than daily." R6's Diagnosis Report dated 7/25/16, identified R6 had diabetes, peripheral vascular disease (PVD), schizophrenia, personality disorder, and bipolar disorder.

R6's progress note(s) dated 9/1/17 to 10/3/17, identified R6 to have numerous, documented episodes of wound and pressure ulcer dressing change refusals, including an entry on 9/13/17, when staff removed R6's sock and, "[approximately] 30 maggots fell on to the floor," R6 was further documented to, "would not have writer do rest of tx [treatment]."

R6's Braden Risk Assessment Scale dated 8/14/17, identified R6 to be at moderate risk of

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pressure ulcer development and skin breakdown. R6's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 8/7/17, identified R6 was at moderate risk of pressure ulcer development and had a history of past pressure ulcers. The care plan listed several interventions including keeping his skin clean and moist, encouraging him to reposition every two hours and, "Complete Push [Pressure Ulcer Scale for Healing] Tool Weekly."

During observation on 10/2/17, at 1:10 p.m. R6 was laying in bed in his room. The bed had an air mattress in place, and R6 had a visible urinary catheter drainage bag sitting on the floor. R6 stated he had pain due to a, "severe wound on my tail bone," which he obtained, "from sitting in the wheelchair." Further, R6 stated staff come in and try to reposition, however, added he doesn't want them to.

During interview on 10/2/17, at 1:42 p.m. registered nurse (RN)-A stated R6 had several current pressure ulcers including a stage 3 or 4 (ulcer extends into the dermis exposing fatty subcutaneous tissue) on his coccyx.

On 10/3/17, at 2:36 p.m. RN-A was going to complete a dressing change to R6's pressure ulcer. R6 declined to have the surveyor observe the wound stating, "He'd rather not."

R6's Skin Grid - Pressure/Venous Insufficiency Ulcer/Other tracking chart dated 9/26/17, identified R6 had a stage III pressure ulcer on his coccyx with an, "Initial Identification," recorded on 9/16/17, measuring 1.8 cm (centimeters) by 0.5 cm by 3.0 cm in size. The ulcer had no recorded tunneling or undermining identified, and no

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drainage or odor present. The tracking chart identified R6 refused to have his ulcer assessed on 9/20/17. The next recorded entry on 9/26/17, identified the ulcer remained a stage III measuring 2 cm by 1 cm by 3 cm in size, however, now had serosanguineous drainage (thin and watery, often pink in color) and mild odor with 5.4 cm of tunneling.

R6's medical record was reviewed and lacked any completed PUSH tools as directed by R6's care plan, nor a comprehensive reassessment of R6's skin risk factors, including his history of refusals, and subsequent interventions to address R6's coccyx pressure ulcer after it worsened on 9/26/17.

When interviewed on 10/3/17, at 1:25 p.m. RN-A stated R6 does not allow his pressure ulcer dressings to be changed often adding the pressure ulcer(s) were primarily tracked using the skin grid tracking charts on a weekly basis. RN-A stated R6's coccyx pressure ulcer was, "getting worse," and staff were trying to have him see a wound physician to help develop a plan to address it. RN-A stated R6 had not allowed the coccyx ulcer to be observed again since 9/26/17. RN-A stated she was unsure what a comprehensive skin assessment would consist of, and added she was unsure where to locate one, if one had been completed, in the medical record. Further, RN-A stated was unaware who was completing the PUSH tool(s) identified on R6's care plan, nor where they were located in the medical record.

During subsequent interview on 10/3/17, at 2:33 p.m. RN-A stated the PUSH tool was used to help determine if the wound was, "getting bigger,

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| F 314 | Continued From page 103<br>getting worse or stalled." RN-A stated the PUSH tools were not being completed, "at this moment," but would be completed on a weekly basis going forward.<br><br>When interviewed on 10/4/17, at 1:37 p.m. the interim director of nursing (DON) stated a comprehensive skin assessment would include completion of the PUSH tool to help determine if the current treatment was effective or if something different needed to be done.<br><br>An undated, uncompleted Pressure Ulcer Scale for Healing (PUSH) tool identified directions to observe and measure each ulcer and total the resulted scores adding, "A comparison of total scores measured over time provides an indication of the improvement or deterioration in pressure ulcer healing." The tool listed a, "Pressure Ulcer Healing Graph," section which ranged in number(s) from 17 (worst possible) to 0 (healed) and allowed staff to identify the pressure ulcer progress. | F 314 | | |
| F 315 SS=E | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>(e) Incontinence.<br>(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- | F 315 | | 11/13/17 |

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| F 315 | Continued From page 104<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide medical justification for use of an indwelling catheter for 2 of 3 residents (R48, R134) reviewed for indwelling catheter. In addition, the facility failed to comprehensively assess the bladder function and put into place interventions to minimize incontinence for 2 of 4 residents (R55, R2) reviewed for urinary incontinence.<br><br>Findings include:<br><br>CATHETER: | F 315 | 1. R48 and R134 have been re-assessed for catheter care and medical justifications have been made to support indwelling Foley catheters. R48 and R134 have been re-assessed for bladder function and care plans have been updated to reflect changes with interventions in place to minimize incontinence.<br>2. Resident that reside at GVHR with a Catheter have the potential to be affected by this practice. Residents currently with Catheters have been re-assessed for the medical justification for needing a catheter | |

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| F 315 | Continued From page 105<br>R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and had an indwelling urinary catheter. Diagnoses included anxiety, depression and a fracture. The MDS did not indicate R48 had diagnoses of neurogenic bladder or obstructive uropathy.<br><br>On 10/3/17, at 9:37 a.m. R48 was observed in her room to have a catheter attached to her right leg draining yellow urine. R48 stated hospice placed a Foley catheter as R48 was having to urinate every two hours and was not getting any sleep. R48 did not display any signs or symptoms of pain.<br><br>R48's Bladder Data Collection and Assessment dated 8/15/16, and reviewed 1/10/17, indicated R48 was continent of urine. The assessment did not identify any form of incontinence or nocturia.<br><br>R48's nursing progress note dated 5/1/17, at 9:00 p.m. indicated R48's hospice nurse inserted a Foley catheter and was to be maintained by hospice. The progress note did not indicate why R48 had a Foley catheter placed and lacked a medical diagnosis. R48's medical record did not indicate R48 had a comprehensive bladder assessment completed when the Foley catheter was placed.<br><br>R48's physician's order dated 8/31/17, indicated R48 had an indwelling Foley catheter with direction for hospice to place and maintain. The order lacked a diagnosis for the Foley catheter.<br><br>R48's physician's order dated 10/2/17, included a diagnosis of incontinence and nocturia for use of the Foley catheter. | F 315 | and changes have been made to plans of care as appropriate. In addition residents with catheters have documentation on size and changing protocols for frequency of the catheter and communicated on the care plans and treatments records. Resident with urinary incontinence that resides at GVHR has the potential to be affected by this practice. Residents assessed for urinary incontinence have been re-assessed and appropriate toileting programs have been care planned as appropriate.<br>3. Clinical leadership, licensed and unlicensed staff have been educated on Catheter implication related to medical justifications. Education has also been provided on bladder assessments and formulating an appropriate plan of care related to care for incontinent residents that improve continence and minimize incontinence.<br>4. DON/Designee will audit 1 resident with a catheter and 3 residents with urinary incontinence weekly for 4 weeks then monthly times 2 months. DON/Designee will review all audits related catheters and urinary incontinence. Results will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br><br>DON to monitor compliance. | |

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On 10/2/17, at 2:40 p.m. assistant director of nursing (ADON)-A stated R48 had an indwelling Foley catheter for incontinence and nocturia.

During interview on 10/5/17, at 9:12 a.m. ADON-C stated she felt incontinence and nocturia was not a reason to place a Foley catheter.

During interview on 10/5/17, at 10:14 a.m. ADON-A stated the physician diagnosis on 10/2/17, was obtained at that time because R48's record lacked a diagnosis for the use of a Foley catheter when requested by the surveyor. ADON-A stated hospice placed the Foley catheter prior to her start of employment at the facility, however, she felt education should have been given to hospice prior to placing the catheter, as incontinence and nocturia were not acceptable reasons to place a Foley catheter. ADON- A stated if R48 was having issues with frequency of urination a comprehensive bladder assessment should have been completed. She indicated prior to use of the catheter, alternatives should of been considered such as offering a bed pan, overnight briefs, medication review, and review of R48's sleeping patterns.

During telephone interview on 10/5/17, at 11:25 a.m. hospice registered nurse (RN)-F stated the catheter was placed as R48 had complaints of having to get up out of bed every two hours to urinate. RN-F stated R48 did have pain, but it was managed by her current pain medications.

The facility policy Indwelling Catheter dated 7/15, indicated: "The center strives to ensure that a resident who enters a center without an indwelling catheter is not catheterized unless the resident's

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clinical condition demonstrates that catheterization was necessary. All residents with an indwelling catheter require a medical justification for the initiation and continuing need for catheter use. A comprehensive assessment includes underlying factors supporting medical justification, determination of which factors can be reversed and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days."

R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had a catheter. R134's care plan dated 10/17, indicated he had a history of urinary tract infections and had a Foley catheter. R134's Urinary Incontinence Care Area Assessment (CAA) dated 7/27/17, indicated he needed total dependence with toileting and was incontinent of bowel and bladder and staff managed all incontinence cares and used incontinent products. The CAA assessment indicated he had urinary urgency and needed assistance with toileting. The CAA failed to indicate he had a catheter.

R134's hospice care plan dated 07/07/17, indicated he had alteration in bladder elimination and had an indwelling urinary catheter.

On 10/03/17, at 8:22 a.m. R134 was observed in the dining room to have a catheter bag attached below his Broda chair (tilt and space positioning chair).

During interview on 10/05/17, at 8:43 a.m. assistant director of nursing (ADON)-B stated

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| F 315 | Continued From page 108<br>R134 had went to the hospital in July 2017 when he was on third floor and transferred to first floor when he returned from the hospital. ADON-B stated his catheter bag should be changed weekly and the catheter should be changed monthly. ADON-B stated this was not put on his orders when he returned from the hospital and she was not sure if either had been completed since they had no orders.<br><br>During observation 10/05/17, at 8:59 a.m. R134 was observed in bed. His indwelling catheter was observed attached to the left side of the bed. The catheter anti-reflux valve and tubing inside was covered in a thick, mucus grey matter.<br><br>During interview on 10/05/17, at 9:00 a.m. nursing assistant (NA)-J stated he did not normally see grey sediment on a catheter. He indicated R134 had been in the hospital and returned on first floor with the catheter. NA-J stated staff empty the catheter bag each shift.<br><br>During interview on 10/05/17, at 9:11 a.m. ADON-B stated the facility should have orders on when to change the catheter, bag and tubing and indicated she was unable to locate orders for R134. ADON-B stated she would assume staff had not changed the catheter, tubing and bag since he returned from the hospital on 07/05/17 (almost two months). ADON-B further stated she noticed the sediment in the catheter and did not know why he had a catheter since he never had one before his hospitalization. ADON-B stated the catheter was placed in the hospital on 6/23/17, and the record did not indicate the reason for the catheter.<br><br>During interview on 10/05/17, ADON-B stated she | F 315 | | |

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had contacted R134's physician and received orders to remove the catheter since the facility did not have a reason for R134 to have the catheter. ADON-B further indicated she had taken his vital signs and his temperature was 98.2 and had no signs of sepsis.

Although R134 had a indwelling catheter the facility failed to have medical justification for the catheter and orders to maintain the catheter.

A facility Procedure Indwelling Urinary Catheter effective July 2015, included to inform care giving team of plan, educate on techniques and interventions as indicated.

URINARY INCONTINENCE:

R55's quarterly MDS dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with toileting. The MDS included a diagnosis of dementia and had moisture associated skin damage. The MDS also identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. A trial toileting program had not been attempted since admission. R55's Urinary Incontinence CAA dated 12/19/16, indicated R55 triggered for further assessment due to extensive assistance with toileting and was always incontinent of urine. Modifiable factors contributing to incontinence included: pain, urinary tract infection, constipation and restricted mobility. Other factors listed were urinary urgency and need for assistance in toileting. A care plan was to be developed to maintain R55's current level of functioning.

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The facility was unable to provide a comprehensive bladder assessment completed for R55.

R55's Urinary Continence care plan, revised on 7/17/17, indicated R55 had functional incontinence and included interventions of prompted voiding upon rising, before and after meals, at bedtime and individualized times. The care plan did not identify the individualized times. The care plan also indicated R55 was to use an adult pull up and for staff to change the pull up as needed.

R55's undated nursing assistant care sheet indicated R55 had "functional incont. [incontinence] upon rising, before and after meals and at bedtime. " The nursing assistant care sheet did not direct staff on what type of assistance R55 needed with toileting.

During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap. During this time, R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting with her. At 11:18 a.m. the social services director (SSD) brought R55 onto the elevator to bring her for a cigarette. SSD did not address R55's urinary incontinence.

During interview on 10/3/17, at 11:02 a.m. health unit coordinator (HUC), who indicated she was at the nursing desk for a large part of the day, stated R55 was soiled with urine about three to four times a week.

During observation on 10/4/17, at 6:49 a.m. R55

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was seated in her wheelchair near the elevators and nursing desk. R55 stated she was waiting to go out for a cigarette at 9:00 a.m.. At 7:08 a.m. assistant executive director (AED)-B took R55 outside to smoke, after smoking AED-B brought R55 back to the 4th floor and brought her to the dining room for breakfast. At 8:07 a.m. after breakfast, NA-H brought R55 to her room and cleaned her nails. NA-H did not offer to toilet R55 at this time following breakfast and after R55's nails were cleaned, she moved R55 back to the area near the elevator and nursing desk. At 8:56 a.m. NA-I brought R55 to her room and assisted with removal of her chin hair and clipped her nails. NA-I did not offer to toilet R55 at this time. At 9:05 a.m. R55 was assisted outside to smoke by NA-I. At 9:08 a.m., after smoking, NA-I wheeled R55 to the dining room to watch television at 9:08 a.m. NA-I did not offer assistance with toileting at that time.

During interview on 10/4/17, at 9:43 a.m. NA-I was not sure when R55 had last been toileted. NA-I stated NA-H was assigned to her for the day and she only shaved her chin and cut her nails. NA-I stated she did not offer to toilet R55 during those cares.

During interview on 10/4/17, at 9:46 a.m. NA-H stated she had not toileted R55 today, but R55 was incontinent of urine when she woke her up that morning and changed her brief. Further, NA-H stated the staff do not toilet R55, but check and change her brief once in the morning and once in the afternoon, when the staff lay her down for a nap. NA-H stated the staff would change her in between those times if her pants are wet. NA-H stated after assisting another resident she would bring R55 back to her room and check her pad.

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During observation on 10/4/17, at 9:55 a.m. NA-H brought R55 back to her room. R55 indicated there were no sheets on the bed because, "I probably wet them last night." R55 further stated she would like to go on the toilet, but the staff just check and change her brief. NA-H then assisted R55 to transfer from her wheelchair to her bed. With gloved hands NA-H changed R55's incontinent brief, which was saturated with urine. NA-H stated R55's brief had a large amount of urine in it. Further, she had to remove R55's bed linens that morning because the linens were wet with urine. She indicated it was usual to change R55's linens in the morning because the linens were wet.

During interview on 10/5/17, at 10:01 a.m. ADON-A stated R55 did not have a current bladder assessment. ADON-A stated per the care plan, R55's incontinence was functional and related to inability to transfer herself. ADON-A stated a bladder assessment should include 72 hours of bladder monitoring to effectively determine R55's toileting patterns and subsequent scheduling needs. ADON-A further stated R55 was to be toileted and not checked and changed. ADON-A indicated R55 needed to be reassessed for her toileting needs as she had never seen R55 toileted. ADON-A also stated R55 was not being toileted according to her current care plan of upon rising, before and after meals and at HS.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance for toileting. The MDS identified diagnoses of benign prostatic hyperplasia (BPH) and schizophrenia. The MDS

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also identified R2 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. The MDS indicated a trial toileting program had been attempted with no improvement noted and R2 was on a current toileting program. R2's Urinary Incontinence CAA dated 8/19/17, indicated R2 triggered for further assessment due to extensive assistance with toileting and was frequently incontinent of urine, as well as moisture associated skin damage. Modifiable factors contributing to incontinence included: psychological or psychiatric problems and restricted mobility. Other factors listed were urinary urgency and need for assistance in toileting. A care plan was to be developed to improve R2's current level of functioning and avoid complications.

R2's Bladder Data Collection and Assessment dated 4/4/16, and reviewed on 5/11/17, indicated R2 was always incontinent. Signs and symptoms included: "clothes wet, bedwetting, and wears pads." The assessment also indicated R2 had excessive intake of caffeine beverages and / or bladder irritants. The assessment identified R2 had urge and functional incontinence with a treatment program of prompted voiding, however, no scheduled times were provided for the prompted voiding program.

R2's Urinary Continence care plan last reviewed 8/4/17, indicated R2 was incontinent and resident refused to wear incontinent products and occasionally soiled self. The care plan included a behavior which indicated R2 would lie in bed and urinate, soiling himself and the bed and refused to be changed was noted. However, the care plan did not address how the staff should handle the

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behavior, other than to encourage him to change his clothing. The care plan indicated to provide R2 with incontinent briefs and directed staff to offer prompted voiding at individualized times of offering every two hours and as needed. The care plan also directed staff to check and change R2 at individualized times as resident refuses to toilet himself. The care plan did not include individualized times for toileting needs for R2 and listed conflicting information of toileting and check and change.

R2's undated nursing assistant care sheet directed staff to "remind to toilet q2h [every two hours], chart both inc [incontinent] and cont. [continent]."

During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweatpants were wet in the front and back, as well as the right lower side of his shirt. Multiple staff were located around the nursing desk and no staff members offered to assist him with toileting. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated. R2's room had a strong odor of urine present that could also be smelled in the hallway.

During interview on 10/3/17, at 11:02 a.m. HUC stated R2 was soiled with urine about three to four times a week. She stated in the past, she had to direct R2 to his room to change out of urine soiled clothing, because the nursing staff did not have the time to assist him. HUC stated she directed R2 to his room to clean himself and change out of his wet clothes on 10/2/17, because the nursing staff did not have time to assist him.

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During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff were aware when R2 was soiled, but were unable to assist R2 due to the lack of staffing.

During interview on 10/5/17, at 9:39 a.m. ADON-A stated she did not recall seeing R2 walking around with clothing saturated with urine on 10/2/17, however, staff should have assisted him. ADON-A stated R2 should have been offered to toilet and any refusals should be charted and the nurse alerted, so other staff could try and assist R2. ADON-A stated she was aware R2 removed and refused to wear briefs, but was not sure if adult pull ups had been tried. After reviewing R2's bladder assessment dated 5/11/17, ADON-A stated she did not agree with the assessment and felt R2 needed to be re-assessed and interventions looked at as she was not sure why there were no individualized times set for toileting R2.

R2's Behavior Detail Report from 7/7/17 to 10/4/17, indicated R2 resisted care one time on 9/16/17, and staff was able to redirect R2. The report did not include any further incidents of resisting care.

The facility policy Urinary Incontinence dated 7/15, indicated: "The center strives to ensure that residents who are incontinent of bladder receive appropriate treatment and services to restore as much normal bladder function as possible." The policy directed: "The care process is followed

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| F 315 | Continued From page 116<br>(accurate assessment, care planning, consistent implementation and monitoring of the care plan with<br>evaluation of the effectiveness of the interventions and revision, as appropriate) to appropriately manage urinary incontinence. Recording and evaluating specific information (such as frequency and times of incontinence and toileting and response to specific interventions) is important for determining progress, changes, or decline. Various conditions or situations may aggravate the severity of urinary incontinence. Steps should be taken to alter these conditions/situations whenever possible." | F 315 | | |
| F 318 SS=D | 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>(c) Mobility.<br><br>(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to consistently provide range of motion (ROM) services for 1 of 2 residents (R121) reviewed whom had a limited range of motion and restorative nursing.<br><br>Findings include: | F 318 | 1. R121 has been re-assessed for ROM services and plan of care has been updated as appropriate. Resident is currently receiving ROM services per Plan of Care.<br>2. Residents requiring Range of Motion services for maintenance and or | 11/13/17 |

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| F 318 | Continued From page 117<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent upon and required the physical assistance of two staff for bed mobility, eating, dressing, toileting and personal hygiene. A facility document, Therapy Recommendations for Restorative Program for R121, dated 4/6/17, indicated "Passive and/or Active Range of Motion." R121's Restorative Program History report, printed 10/4/17, indicated R121's passive ROM program goal to be: Resident will maintain current range of motion with assistance of doing PROM to bilateral extremities twice a day for 15 reps each time. The program directed: 1. Explain procedure; 2. Perform PROM to bilateral lower extremities and; Report to nurse any complaints of pain, refusals. R121's mobility care plan, dated 4/17, identified contractures and muscle stiffness as a target problem.<br><br>During interview on 10/2/17 at 6:22 p.m., family member (FM)-C stated she had "a concern" about the ROM programs getting completed. FM-C stated when she visits, she completed the ROM for R121, and stated of late had been rolling towels and places rolled up hand towels in R121's hand to keep them from rolling up and getting tight. FM-C stated she "questioned" if (R121's) ROM program was getting done. FM-C stated R121 was to get ROM twice daily, but stated "I'm not sure staff are doing that."<br><br>During observation on 10/3/17 at 8:18 a.m., R121 was lying in his bed in his room, facing the window, a pillow under his left side. R121's arms | F 318 | prevention have the potential to be affected. Residents requiring Range of motion services have had medical record reviews and updates have made as appropriate.<br>3. Licensed nurses and NARs have been re-educated on restorative services. Facility has added a Restorative champion to manage the program.<br>4. DON/Designee to audit 3 residents to ensure ROM services are being provided and documentation is in place weekly for 4 weeks then monthly times 2 months. Results will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br><br>5. DON to monitor compliance. | |

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were at his side, elbows folded and forearms at 45 degree angle from his elbow, and situated upon his stomach. R121 wore heel boots, bilaterally, on his feet. During continuous observation from 8:18 am to 11:32 a.m., R121 remained lying on his bed in his room. At 9:29 a.m., nursing assistant (NA)-D and registered nurse (RN)-B repositioned R121. At 11:32 a.m., RN-B, NA-D and NA-B assisted with R121 with a dressing change and repositioning. At 1:58 p.m., R121 was again repositioned by NA-B and NA-D. R121 was not offered nor was provided any range of motion during any of the visits by nursing staff during these time frames.

During interview on 10/3/17 at 2:06 p.m. NA-D stated she assisted R121 only to reposition and did not do any kind of ROM exercises. NA-D stated she "did not think" R121 has any range of motion or exercise program.

When interviewed on 10/3/17 at 4:38 p.m., RN-B stated R121 did not have any orders for restorative nursing. RN-B stated if there was a program from therapy, "licensed staff would be doing that." RN-B stated there were no orders in the treatment record for range of motion for R121. RN-B stated, however, R121 could benefit from a ROM program, so (R121) could keep his arms and hands "more limber."

During observation of the morning routine on 10/4/17 at 9:42 a.m., NA-A and NA-C assisted R121 with morning cares, including repositioning and oral cares. There was no provision or offer to complete range of motion for R121 during his morning routine.

When interviewed on 10/4/17 at 9:48 a.m., NA-C

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stated R121 did not have a range of motion program, and has not assisted him with that. NA-C stated often therapy often worked with resident in their rooms, but has not seen anyone work with R121 in his room. NA-C stated she did not perform ROM for R121.

During an interview on 10/4/17 at 9:59 a.m., NA-A stated she did not think R121 had any range of motion program, and if he did, we would have had "someone from therapy" show us what to do. NA-A stated she did not help R121 with any exercise or range of motion.

A review of the ROM (Range of Motion) detail report from 7/8/17 to 10/4/17 indicated the following number of times ROM was provided R121; number of refusals; and number of times ill:
July 20x (times) ROM; 4x refusals; and 2x ill
August 34x ROM; 1x refusal; and 2x ill
September 15x ROM; 3x refusals; 1x ill
October (through 10/4) 2x ROM; 0x refusals; 0x ill

During interview on 10/4/17 at 7:43 a.m., the director of therapy (DT) stated R121 has been on therapy case load a number of times. Upon his return from hospitalization in early April, a restorative program was recommended for R121. The DT stated she was at R121's care conference about two months ago and recalled a discussion that ROM that was being completed for R121. She was unable identify how his ROM program was being monitored for compliance. The DT stated R121 had muscle contractures and would be a candidate for passive range of motion exercises.

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| F 318 | Continued From page 120 When interviewed on 10/4/17 at 8:16 a.m., physical therapist (PT)-A stated R121 was evaluated last April, following hospitalization. At that time R121 was unable to actively participate in range of motion and his condition has remained unchanged. PT-A stated R121 definitely "would benefit" from ROM and described the plan to include PROM to legs, knees, ankles, bilaterally, and usually 10 reps (repetitions) each, and the exercises be done twice daily.<br><br>When interviewed on 10/4/17 at 8:43 a.m. the assistant director of nursing (ADON)-C stated R121 had a restorative program and futher the aides should be completing that task, during cares or when repositioning. The ADON questioned how R121 could be 'refusing' the program because of his current disposition and stated the ROM program was to be completed twice daily, 15 reps each time. ADON-C also stated even though this was not "spelled out" in the care plan, the instructions for restorative program in care tracker was part of the care plan, and she "expected" R121 was to receive range of motion services.<br><br>A facilty policy, Contracture Prevention, dated July 2015, indicated as it purpose "To maintain or improve joint mobility to assist resident in maintaining or achieving independent function, or preventing or reducing contracture or deformity. The Policy included providing PROM (passive range of motion) as an intervention to achieve the goal. | F 318 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES | F 323 | | 11/13/17 |

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(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 2 of 4 residents (R21, R20) reviewed for smoking.

Findings include:

R21's quarterly Minimum Data Set (MDS) dated 8/23/17, identified R21 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs).

F 323

1. R20 no longer resides at GVRH. R21 has been re-assessed for smoking and care plan has been updated to reflect changes.
2. Residents that reside at GVRHC that choose to smoke have the potential to be affected by this practice. Residents that choose to smoke have had their medical records reviewed and new smoking assessments completed with plans of care updated as appropriate. Smokers that are not deemed safe to smoke

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| F 323 | Continued From page 122<br>A Resident Smokers listing dated 9/29/17, was provided upon entrance to the facility on 10/1/17. The listing identified all current smoking residents which included R21.<br><br>On 10/1/17, at 3:37 p.m. R21 was seated in her room in her wheelchair. R21 stated she was waiting to go outside to smoke adding, "I smoke on my own," after staff help her get outside.<br><br>During subsequent observation on 10/2/17, at 12:50 p.m. R21 was outside on the patio by the main entrance with other residents, including R96, smoking with a lit cigarette in her right hand. No staff were present outside on the patio with R21, and she had no visible smoking apron on. R21 was able to bring the cigarette to her mouth and ash without dropping any ash(es) on herself or her clothing. R21 stated, "People [staff] always take me," outside to smoke adding they light the cigarettes for her. At 12:58 p.m. activities aide (AA)-A approached R21 while outside smoking and conversed with her. AA-A invited R21 to bingo stating he would, "come back out here when you're done smoking," and bring her back inside. Afterwards, R21 was approached by another resident, R134, who asked her for her lit cigarette. R21 handed her lit cigarette to R134 who used it to light his own cigarette. At 1:02 p.m. registered nurse (RN)-A brought another resident outside to smoke and observed R21 smoking. RN-A asked R21 aloud, "who gave you a cigarette?" R21 responded to her, "I smoked it already," after throwing it on the ground next to her wheelchair.<br><br>R21's medical record was reviewed. A completed Smoking Safety Data Collection and Assessment dated 10/2/17, identified R21 was | F 323 | independently have had intervention put into place and care plans have been updated.<br>3. Department heads, licensed staff and unlicensed staff have been educated on following the resident plan of care in relation to smoking. Clinical leadership and operations have been educated on appropriate assessments and formulating safe plans of care for residents who wish to smoke.<br>4. ED/Designee to perform audits on compliance of smoking policy 3 times a week for 4 weeks then monthly times 2 months. ED/Designee to audit 2 charts per week for compliance of smoking policy 3 times a week for 4 weeks then monthly times 2 months for accurate smoking assessments and plans of care for safety. Results will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.<br><br>ED to monitor compliance. | |

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| F 323 | Continued From page 123<br>unable to communicate understanding of the smoking standards and procedures, did not demonstrate appropriate use of an ashtray, nor ability to appropriately extinguish a cigarette. R21 was identified to be a "dependent smoker," and directed to refer to the facility smoking policy for supervision requirements. The assessment was signed on 10/2/17, by assistant director of nursing (ADON)-A (the same day the surveyor observed R21 smoking outside without staff supervision).<br><br>R21's progress note dated 10/2/17, at 1:25 p.m. identified an entry of, "[R21] was outside smoking. Smoking assessment completed. Resident is deemed a dependent smoker. Smoking materials removed from resident & [and] put in med room."<br><br>When interviewed on 10/3/17, at 9:28 a.m. nursing assistant (NA)-F stated R21 used to smoke but, "does not anymore." NA-F stated R21 was not going outside to smoke to her knowledge.<br><br>During interview on 10/3/17, at 9:51 a.m. ADON-A stated R21 was not a smoker until yesterday when staff found cigarettes in her room. ADON-A stated she was directed to complete a smoking assessment yesterday because R21 went outside and was smoking. ADON-A stated she was not sure why R21 had been included on the list of smokers presented upon entrance, however, added it was important to assess safety with smoking for residents to prevent injury or burns.<br><br>R96's annual MDS dated 6/21/17, identified R96 had intact cognition. When interviewed on 10/3/17, at 3:04 p.m. R96 stated staff bring R21 | F 323 | | |

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outside to smoke, and had done so several times in the past.

When interviewed on 10/3/17, at 3:06 p.m. assistant executive director (AED)-B stated the Resident Smokers listing provided on entrance was created by asking the nurse managers and social services staff on each floor who is currently smoking. AED-B stated the listing was current upon the survey team entrance as, "that's who they [staff] gave me," as current smokers.

R20's Admission Record, dated 10/3/17, identified resident had multiple mental health diagnoses, in addition to heart failure, hypertension, and diabetes.

R20's quarterly MDS dated 7/9/17, identified moderate cognitive impairment with fluctuating episodes of attentiveness and disorganized thinking, as well as moderate symptoms of depression. R20 was noted to receive extensive assistance with transfers and supervision for locomotion on the unit. The MDS failed to identify R20's tobacco use status.

During interview on 1/03/17, at 9:49 a.m. the hospice nurse (HN)-A identified R20 "Loved to smoke." HN-A stated R20 experienced a fall while outside smoking independently during the night shift, and shortly thereafter was unable to go out unsupervised.

Upon review of nursing progress notes of

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8/22/17, at 3:50 a.m. it was noted R20 was found on the floor in front of the facility at 2:45 a.m.. R20 was noted to have a cut on bridge of the nose and was sent to the emergency room for evaluation and treatment, returning to the facility at 5:15 a.m.. A subsequent note of 8/23/17, at 5:30 a.m. identified R20 was non-compliant with supervised smoking and a 15 minute check was initiated. A review of progress notes did not identify any additional information regarding 15 minutes checks or smoking activities. A progress note of 9/1/17. identified R20 had been noted to be in the parking lot on two occasions. The note further stated R20 had been advised if she continued to go outside without supervision to smoke, a wanderguard would be placed due to her lack of physical capacity to get back into the facility and potential for injury with traffic. An order was obtained on 9/1/17, for use of a wanderguard and this was placed on R20.

A review of R20's care plan noted R20 was at risk for injury related to smoking. The care plan noted a smoking assessment had been completed on 10/26/16, and identified R20 met the criteria to smoke independently. A subsequent smoking assessment, dated 2/13/17, identified R20 was felt to be a dependent smoker (requiring supervision) due to cigarette burn holes noted in clothing and would require supervision with smoking. The care plan did not reflect any change in status, indicating a need for supervision. The care plan review and signatures were in place for 5/11/17 and 8/11/17, with no changes made to care plan interventions. The care plan did not reflect recent placement of wanderguard for safety, effective 9/1/17.

During interview on 10/3/17, at 2:37 p.m. the

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| F 323 | Continued From page 126<br>health unit coordinator (HUC)-A stated R20 did require supervision with smoking for the last two weeks prior to her death on 9/23/17, however, was unsure of the rationale as this was under the direction of upper management. R20's cigarettes were kept in the medication room once supervision was required.<br><br>During interview on 10/03/2017, at 2:53 p.m. NA-U stated R20 had been independent with smoking but was aware this had changed approximately two to three months ago, although was unaware of the reason.<br><br>During interview on 10/3/17, at 2:57 p.m. NA-T stated R20 had been independent with smoking until the last month, when she required supervised smoking due to weakened health.<br><br>During interview on 10/5/17, at 10:57 a.m. the director of social services (DSS) stated R20's mood state was impacted upon availability of cigarettes, stating that when her supply was gone R20 would pick up cigarette butts off of the ground. The DSS stated staff members were aware of this behavior and this contributed to placement of the wanderguard. The DSS stated he had not observed R20 ashing on herself, posing a risk for burns.<br><br>During interview on 10/5/17, at 11:14 a.m. with ADON-A and ADON-D. ADON-A stated R20 had previously been independent with smoking, however, as her health declined R20 was unable to get in and out of facility easily and a wanderguard was placed at that time.<br><br>ADON-D stated the use of the wanderguard alarm did not affect R20's ability to smoke, but | F 323 | | |

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| F 323 | Continued From page 127<br>alerted staff of resident attempts to exit without supervision. A review of the care plan was completed by ADON-D and noted R20 was noted to be an independent smoker, and a revision had not been make following the assessment of 2/13/17.<br><br>ADON-A stated was unaware R20 was to have been a dependent smoker, further stating if an assessment had any indication for dependent smoking the care plan should have been updated. ADON-A stated due to staff turnover, a comprehensive care plan review had not been done.<br><br>A facility MN (Minnesota) Smoking Policy dated 4/2017, identified the facility allows smoking for residents, "...who have been assessed to be independent smokers or have a safe smoking plan in place." Further, the policy directed staff to evaluate smoking abilities upon admission, quarterly and with any significant change in condition. | F 323 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or | F 329 | | 11/13/17 |

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| F 329 | Continued From page 128<br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to record indications for use with as needed (PRN) antipsychotic medication to ensure appropriate monitoring for 1 of 5 residents (R6) reviewed for unnecessary medication use.<br><br>Findings include:<br><br>R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs) and displayed rejection of care | F 329 | 1. R6 has received a medication regimen review and updates were made as appropriate. R6 received a record review with target mood and behavior program updates to include individualized non-pharmaceutical interventions to be used prior to drug therapy.<br>2. Resident that reside at GVRH that currently receive PRN psychoactive medications have the potential to be affected by this practice. Resident that receive PRN psychoactive medications | |

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and verbal symptoms on a less than daily basis.

R6's most recent signed physician orders dated 9/6/17, listed R6's current medications including order(s) for:
- Zoloft (an antidepressant medication) 200 mg (milligrams) by mouth every bedtime for depression;
- Risperdal (an antipsychotic medication) 3 mg by mouth every bedtime for a listed diagnosis of, "anxiety" and;
- Risperdal 0.5 mg, "by mouth twice daily as needed for depression." The PRN dosing had a listed start date of 6/14/17.

R6's medication administration record(s) (MAR) were reviewed. In August 2017, R6 did not take any of the PRN Risperdal. In September 2017, R6 received the PRN Risperdal once on 9/16/17, twice on 9/17/17, once on 9/21/17, and once on 9/27/17, for a total of five administrations. On the back side of the MAR, a column listing was labeled, "Comments/Nursing Observations," and provided directions for staff to identify why any medications had been withheld and, "When PRN medications are given, explain in Nurse's Medication Notes." However, the entire column section was left blank and uncompleted.

R6's Psychiatric Progress Note dated 9/21/17, identified R6 had a history of schizoaffective disorder, bipolar type with staff reporting him to be, "seemingly stable and doing well overall." R6 was documented as having, "more difficulty keeping positive," due to poor wound healing, however, listed an assessment section with, "There have been no concerns reported by nursing staff." Further, dictation is listed of, "Of note, it does appear that he has been asking for

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have received a medication regimen review with updates made to plans of care as appropriate. Non-pharmaceutical interventions have also been created based off an individual assessment and care approach. Non-pharmaceutical interventions to be attempted and documented prior to medication administration.

3. Clinical leadership, licensed staff, and Social service have been educated on Target Mood and Behavior programs for resident receiving psychoactive medications and on approaching initially with a non pharmaceutical approach.

4. DON/Designee to audit 2 residents receiving PRN antipsychotics for target behavior programs and monitoring weekly for 4 weeks then monthly times 2 months. Results will be brought to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.

DON to monitor compliance.

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his Risperdal p.r.n. on a few occasions since this provider reminded him that this is available to him if needed to target depression, anxiety, or unclear thinking."

R6's Behavior Chart Detail Report dated 8/5/17 to 10/3/17, identified R6 had no recorded behaviors on the dates the PRN Risperdal was provided. Further, R6's progress note(s) dated 8/5/17 to 10/3/17, lacked any recorded indications or rationale for the PRN Risperdal being provided.

When interviewed on 10/4/17, at 9:32 a.m. nursing assistant (NA)-G stated R6 was particular in how staff cared for him and, "very non-compliant," at times with thinking staff didn't have equipment to help him, so he would refuse cares. NA-G stated she was unaware of R6 having any hallucinations or other delusional thinking, and further stated any behaviors R6 displayed would be reported to the nurses and charted.

During interview on 10/5/17, at 8:10 a.m. licensed practical nurse (LPN)-F stated R6 received the PRN Risperdal for depression and sometimes would ask for it when screaming or yelling at the staff. LPN-F stated the usual facility practice was for R6's progress notes, or the back side of the MAR, to have documentation to support why the PRN Risperdal had been given in September. However; after reviewing R6's record with the surveyor added it was not and, "its supposed to be there."

On 10/5/17, at 8:41 a.m. registered nurse (RN)-A and assistant director of nursing (ADON)-A were interviewed. ADON-A stated staff should be documenting, "the indication," for giving as

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| F 329 | Continued From page 131 needed medication on the back side of the MAR or in the progress notes. ADON-A stated it was important to document rationale for giving as needed medication, "so you can determine the effectiveness of the medication," and to ensure, "it was necessary."<br><br>Although R6 had orders for PRN Risperdal, the staff failed to document the reasoning and indication when they administered it to allow periodic assessment and evaluation to determine if the medication was being effective and/or still warranted.<br><br>A facility Psychoactive Medication policy dated 1/2016, directed staff to document, "PRN medication use as applicable," on the care plan and CareTracker system, and staff would completed a review of psychoactive medication use when applicable and during the RAI (Resident Assessment Instrument) process. | F 329 | | |
| F 353 SS=F | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br>[As linked to Facility Assessment, §483.70(e), will | F 353 | | 11/13/17 |

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| F 353 | Continued From page 132<br>be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 of 5 residents (R55, R2, R183) whom were dependent upon staff for ADL's, 2 of 4 residents (R134, R121) reviewed for pressure | F 353 | Correction/s as it relates to the resident/s: R55, R2, R183, R134, R121, R19, R97, R48, R28, R196, R180, R162, R47, R6, R31, R24, R82, R130, R192, R43, R31, R66, R183 have individual corrections in place per the plan of correction. Staffing | |

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ulcers, for 1 of 2 residents (R121) reviewed for range of motion, 2 of 2 residents (R19, R97) reviewed for paid feeding assistant, and 16 residents (R48, R28, R196, R180, R162, R47, R6, R31, R24, R82, R130, R192, R43, R31, R66, R183) and 14 staff members (RN-C, HUC-A, NA-C, RN-E, RN-G, ADON-A, HN-A, LPN-E, LPN-I, NA-E, NA-G, NA-H, ADON-C, AS) whom voiced concerns with the lack of sufficient nursing staff in the facility. This had the potential to affect all 94 residents in the facility.

Findings include:

ADL's NOT MET:
R55 was observed on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair with a strong smell of urine and had a saturated wet area of her lap. R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting with her. At 11:18 a.m. the social services director (SSD) brought R55 onto the elevator and brought outside for cigarette. SSD did not address R55's urinary incontinence.

R2 was observed on 10/2/17, at 2:10 p.m. standing at the nursing desk with a strong smell of urine. His sweat pants were wet in the front and back, as well as the right lower side of his shirt. Multiple staff were located around the nursing desk and no staff members offered to assist him with toileting. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated. R2's room had a strong odor of urine present that lingered into the hallway. During interview on 10/4/17, at 9:12 a.m. NA-G stated they were aware of R2's needs but were unable to assist R2 due to the lack of staffing.

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level was increased on 1st floor to include an additional NAR and TMA or licensed nurse on AM and PM shift and additional NAR was added on 4th floor on AM and PM.
Actions/s taken to protect residents in similar situations: Staffing will be reviewed daily by the Executive Director to ensure appropriate quantity, quality and composition of staff to meet resident needs. Caring Partner program interviews will be conducted by the IDT to gather feedback from residents/responsible parties related to staffing concerns. Resident Council will be interviewed regarding concerns regarding staffing and availability/accessibility of supplies to include linens and routine care supplies. Rounds will be completed by DON/ED and nurse managers at a minimum of 2x daily to observe care and services provided to meet resident needs.

Measures taken or systems altered to ensure that solutions are sustained: Resident Centered Staffing Committee (RCSC) created to implement and monitor center's ongoing acuity level. Acuity staffing assessments will be conducted by the resident centered staffing committee at a minimum of monthly on long term care units and weekly on TCU to determine staffing ratios and staff deployment related to level of care. ED, DON, and Staffing coordinator have been educated on the acuity based staffing methodology by the Executive Director of Clinical Services. ED, DON and staffing coordinator will review staffing on a daily

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R183's admission MDS dated 8/3/17, identified R183 had intact cognition and required extensive assistance to complete all ADL's except eating. On 10/1/17, at 3:44 p.m. R183 while laying in bed had a strong, pungent odor of perspiration and other body odors. He stated he had not yet received one bath since admission to the facility greater than two months ago.

PRESSURE ULCERS
R134's Skin Integrity Assessment: Prevention And Treatment Plan Of Care dated 10/03/17, directed staff to reposition R134 every two hours. During continuous observation 10/03/17, from 8:35 a.m. to 11:07 a.m. (2 hours and 32 minutes) R134 was observed to be sitting in his Broda chair (tilt and recline positioning chair), without being repositioned/toileted or check and change. At 11:07 a.m. surveyor informed nursing assistant (NA)-M and NA-J that R134 had not been repositioned for over 2 hours and 30 minutes. NA-M stated she had assisted NA-N and they do not have enough staff to reposition resident timely.

R121's Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent and required the physical assistance of two staff for bed mobility, and toileting and had a current pressure ulcer. During continuous observation on 10/3/17, from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed which remained unchanged. During an interview on 10/3/17, at 2:06 p.m., nursing assistant (NA)-D stated we got busy, and R121 should be checked and turned every two hours.

ROM

basis to determine need for adjustments related to the acuity of the residents with input from the floor staff working the assigned units.

Plans to monitor performance to ensure solutions are sustained and person responsible: Caring Partners will interview residents related to staffing and if needs are being met by staff weekly. Any negative responses will be forward to ED for investigation. Resident Council meeting minutes will be reviewed monthly in the Center's QA meeting and action taken as needed. Executive Director and Director of Nursing will conduct rounds M-F to observe care and treatment of residents in relation to staffing and adequate amounts of supplies and linens. Rounds will be completed by the Manager of the Day on Saturdays and Sundays. Director of Operations and Director of Clinical Services will evaluate staffing patterns during weekly visits to ensure adequate staffing to meet resident needs. Evaluations will also include staff and resident interviews. Caring Partner interviews/audit results and other audits will be tracked and trended by the Executive Director and reported monthly x 3 months in the Center's Quality Improvement meeting, and necessary action will be taken as needed. Executive Director and Director of Nursing to monitor compliance.

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R121's Restorative Program History report, printed 10/4/17, identified R121 was to receive passive range of motion (ROM). During interview on 10/2/17 at 6:22 p.m., family member (FM)-C stated R121 was not getting his ROM program exercises. When she visits, she completes the ROM for R121, and has been rolling towels and placing them in his hand to keep them from rolling up and getting tight. When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a range of motion program, and has not assisted him with that.

ASSISTANCE WITH EATING
During interview 10/04/17, at 9:22 a.m. HR-A stated she had been working at the facility since 03/07/17, and became a NA in 2005, her NA certificate had expired in 2008, and she had not renewed her certificate. HR-A stated she assists with feeding when they are short staffed and has assisted R19 and R97.

RESIDENT COMPLAINTS REGARDING STAFFING CONCERNS:
R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact, had an indwelling catheter and required extensive assistance to toilet. During interview on 10/1/17, at 3:55 p.m. R48 stated she needed to empty her own catheter and make her own bed because it took staff one to two hours to answer her call light. Further, R48 stated she had to fight with the facility to allow her nitroglycerin (medication used to treat chest pain) to be left at the bed side, because it took so long for staff to come and administer them medication when she was having chest pain.

R28's quarterly MDS dated 6/20/17, indicated

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R28 was cognitively intact and required extensive to total dependence with ADL's. On 10/1/17, at 4:10 p.m. R28 stated he was unable to get in and out of bed when he liked. Four days out of the week it was common to wait over 30 minutes to get assistance.

R196's admission MDS dated 9/16/17, indicated R196 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 12:19 p.m. R196 stated she had to wait an hour while being on the bed pan and it was uncomfortable. R196 stated the staff put her on the bed pan, leave and tell you to put the call light on and then don't return when the call light is put on.

R180's quarterly MDS dated 9/13/17, indicated R180 was cognitively intact, required supervision for ADL's and received scheduled and as needed pain medications. On 10/2/17, at 12:25 a.m. R180 stated staff often didn't answer call "buttons" for and hour or two, and when they finally answered the light he often was told "I'll tell the nurse." R180 stated it can take a long time to get pain medications, sometimes 45 minutes. The nurses then "make up all kinds of excuses" why they are late.

R162's quarterly MDS dated 8/17/17, indicated R162 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 12:35 R162 stated there was a 20 percent chance your call light will be answered timely. The answer your light and say they need to go get someone to help, then the staff walk out and no one comes back. I was told by a nursing assistant if I needed assistance during lunch I would need to wait, because they

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| F 353 | Continued From page 137<br>were so understaffed there was not anyone to answer call lights during lunch. R162 also stated he was not always getting bathed do to the lack of staff.<br><br>R47's admission MDS dated 9/18/17, indicated R47 was cognitively intact and required extensive to total dependence from staff for ADL's. During interview on 10/2/17, at 12:37 p.m. R47 stated staff were so rushed there were not cleaning under his foreskin.<br><br>R6's quarterly MDS dated 8/11/17, indicated R6 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 1:19 p.m. R6 stated there was not enough staff, and has waited an hour to an hour and a half to have his call light answered. R6 added staff sometimes didn't even answer the call light.<br><br>R31's annual MDS dated 7/24/17, indicated R31 was cognitively intact and required extensive to total dependence of staff for ADL's. On 10/2/17, at 1:19 p.m. R31 who resided on 1st floor stated there were only two to three nursing assistants scheduled on the floor, and it was not enough, as most of the residents on that floor required two staff members to assist with cares and transfers. When staff take their breaks that leaves only one or two staff members on the floor. There is a lack of help during meal times and you can't get assistance to toilet during meal times. He is incontinent two to three times a week, do to the lack of assistance by staff.<br><br>R24's quarterly MDS dated 9/1/17, indicated R24 was cognitively intact and required extensive to total dependence of staff for ADL's. When | F 353 | | |

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| F 353 | Continued From page 138<br>interviewed on 10/2/17, at 1:28 p.m. R24 stated there were not enough nursing assistants and had to wait a half hour or more to have call lights answered. Also at times the call light would be answered and shut off, staff say they would be back and don't come back for two hours. This has happened while being on the bed pan and it "made me very angry." R24 also stated they have been incontinent waiting for staff assistance. I don't feel they have enough staff, and they need more people to take care of the residents. Staff are leaving because of the heavy workload.<br><br>R82's annual MDS dated 6/27/17, indicated R82 was cognitively intact and required extensive to total dependence of staff for ADL's. During interview on 10/2/17, at 1:30 p.m. R82 stated the facility was always short staffed. The management said there was a low census, so they couldn't schedule more staff. R82 stated she needed to wait over an hour at times to have her incontinent product changed. R82 stated that happened at least four times a week and it was worse on the day shift. "I hate even going to the bathroom during the day, because I know I will have to wait."<br><br>R130's quarterly MDS dated 8/15/17, indicated R130 was cognitively intact and required extensive assistance with ADL's. During interview 10/01/2017, at 10:17 R130 stated he had been at the facility for about a year. I hate it here I don't like the staff, I don't like the food. I don't like the staff, they are always understaffed. I takes them forever to answer the call light I wait 45-min to an hour for help. I have had a accident waiting for help that makes me feel horrible. I wear a brief but would like to use a urinal I have to put on my call light on for them to bring the urinal. | F 353 | | |

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When interviewed on 10/2/17, at 2:19 p.m. R130 stated he did not feel there was enough staff in the facility and at times waited 30 to 45 minutes, so I want my urinal and when they don't come I have wet myself and it doesn't make me feel good.

R192's admission MDS dated 9/6/17, indicated R192's was cognitively intact and required extensive assistance with ADL's. On 10/2/17, at 2:28 p.m. R192 stated she has put her call light on and no one answers it for 25 minutes or more.

R43's quarterly MDS dated 8/17/17, identified R43 had intact cognition, required extensive assistance with activities of daily living (ADLs) and had, "total dependence," on staff for transfers. During observation on 10/3/17, at 8:47 a.m. R43 was seated in a wheelchair outside her room with her call light turned on. At 8:54 a.m. (seven minutes later) R43 remained in the wheelchair outside her room. RN-E approached R43 and stated, "Are you waiting for someone to lay you down?" R43 responded she was but, "they [staff] just walk right on by." RN-C stated she would tell staff and walked away. When interviewed immediately following, R43 stated, "I just want to lay down," as she was having pain in her right leg, however, "I don't get help." Further, R43 stated she has waited so long before to get assistance with laying down, "I have one of my anxiety attacks." R43 remained seated in her wheelchair in the hallway until 9:04 a.m. (17 minutes later) when an unidentified NA approached her with the mechanical lift machine and assisted her to lay down.

R31's annual MDS of 7/24/17 identified resident exhibited intact cognition with no signs of

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| F 353 | Continued From page 140<br>delirium. R16 was noted to require extensive assistance of one to two staff to complete ADL's including transferring, position, dressing, grooming and bathing. During interview on 10/2/17 at 12:52 p.m. R31 stated "You get a chance to get a bath once a week or a shower. When they are short staffed, they give a bed bath, which is just a wash down which they should do everyday. R31 stated at times it had been, "Three weeks in a row that I didn't receive a bath." R31 stated it is difficult when there are only two staff on the floor and it takes two staff to complete a shower. If there is not enough staff when you have your scheduled shower day, it gets missed.<br><br>R66's quarterly MDS completed on 9/3/17, indicated R66 exhibited no cognitive impairment and required total to extensive assistance with the activities of daily living (ADL's), including dressing, grooming, bathing and mobility. During interview on 10/1/17, at 4:10 p.m. R66 expressed concern regarding staffing, stating assistance with bathing occurred infrequently. R66 stated if they are short staffed "You don't receive a bath." R66 went on to say he had received assistance to wash his hair on only three occasions in the last year and a half. When placing the call light on to summon assistance, it is not a guarantee you will get help. Staff will often turn off the call light and say that they will come back, but often don't return, or return after an extended period of time.<br><br>R183 stated on 10/1/17, at 3:36 a.m. R183 stated the facility was understaffed. He had been incontinent of bowel and it took over an hour for staff to assist him. R183 stated at one time her called 911 because the staff had left him on the | F 353 | | |

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commode for 45 minutes and it "pissed" him off. Further, he needed to wait long amounts of time to be put to bed and had a pressure ulcer on his buttocks and need to lay down and not wait for staff. R183 stated on 10/05/2017 9:24 a.m a couple of weeks ago, there were only two aides on the floor all day and the evenings. "When you short staff us, we all suffer," and we are not getting the care we need.

STAFF CONCERNS REGARDING STAFFING CONCERNS
Registered nurse (RN)-C stated on 10/1/17, at 10:01 a.m. due to the allowed staffing in the facility, nurses tried hard to get there medication passes completed, however, treatments were not consistently being done as ordered. RN-C further stated the four nursing assistants and two nurses working the cart was not enough staff to meet the resident needs on the 4th floor.

Health unit coordinator (HUC)-A stated on 10/3/17, at 11:02 a.m. the staffing on 4th floor was "horrible." Sometimes the resident needs were not being met as there were a lot of residents that needed two people to assist them. HUC-A added when the staff were in rooms assisting other residents, the residents who had there call lights on waiting for assistance start yelling. There used to be five nursing assistant on 4th floor, but now management was only scheduling four nursing assistants. The HUC added R6 frequently called the facility, when staff did not answer the call light. R55 was soiled with urine about three to four times a week along with R2. She stated she has directed R2 to his room and changed his urine soiled clothing, because the nursing staff didn't have the time to assist him.

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NA-C stated on 10/3/17, at 11:46 a.m. call lights frequently take 30 to 45 minutes to be answered because we are assisting other residents with care and there isn't enough staff. NA-C further stated "that's a long time" to wait to go to the bathroom. NA-C stated resident are frequently incontinent because there are not toileted timely. Maybe if they could be toileted timely they wouldn't be incontinent. The facility will only schedule four aids on the 4th floor and have asked for more staff. The residents are angry with us and think we don't answer call lights timely on purpose.

RN-E stated on 10/3/17, at 2:26 p.m. it can be difficult to get all task completed timely. On 4th floor there are a lot of residents who require two people to assist with cares and when those two people are assisting someone others need to wait. RN-E stated staff can't stop in the middle of a two person transfer to assist someone to change their incontinent product or help someone with toileting.

RN-G stated on 10/3/17, at 2:53 p.m. there are two nursing assistants scheduled to work each wing of the 4th floor, for a total of four nursing assistants. RN-G stated there are at least 11 residents out of 26 on her wing that require two people for transfers and care and the other wing had a lot higher acuity level. We had a meeting with management one to two weeks ago and we brought up staffing concerns and were told it was not in the budget to add more nursing assistants. The management is not taking into account the level of care these residents need. Some residents are leaving and finding new places to live because their needs were not being met do to

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the lack of staff.

Assistant Director of Nursing (ADON)-A stated on 10/3/17, at 3:15 p.m. there are not enough aids scheduled in the facility to begin with. Then they call in and the ADON's need to fill in on the floor, doing cares and passing medications and then we get behind on the assessments and care plans. ADON-A stated there are a lot of complaints from residents regarding not enough staff, but we do the best we can. The facility schedules by amount of resident not there care needs. She stated there have been an increase in falls and incontinence issues related to the staffing levels.

Hospice Nurse (HN)-A from North Memorial Hospice stated on 10/03/17, at 9:30 a.m. the fourth floor does not have enough staff. HN-A stated there is a lot of mental illness on that floor and one evening there was a nurse who said she had 52 residents with only a nurse and two trained medical assistance (TMA)'s and you can't meet all of there needs, and had concerns with pain medications not being given as ordered and physician orders not being transcribed.

Licensed practical nurse (LPN)-E stated on 10/03/17, at 2:57 p.m. she works on the first floor and is the only nurse working on the floor. LPN-E stated they recently, with in the last month moved five residents from the third floor to first floor and were told they where going to get more staff to now help out but it never happened. LPN-E stated she was supposed to get a trained medical assistant (TMA) to help with medication pass but that didn't happen either.

LPN-I stated 10/03/17, at 3:01 p.m. they do not

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| F 353 | Continued From page 144 have enough staff on first floor especially because so many of the residents are bariatric residents (bariatric's is the field of medicine that specializes in treating morbid or extreme obesity) and require assist of two. LPN-I stated she feels bad for the nursing assistance and end up helping them and then drowning in her own work and the patients get mad waiting. LPN-I stated "sometimes I feel my job is impossible". In addition LPN-I stated the aides can't get there charting done.<br><br>NA-E stated on 10/4/17, at 12:36 p.m. here were days that staff are not always able to complete their assignments, such as toileting, getting baths completed and shaving done. They are late in helping in the dining room while having to answer lights. NA-E added it is difficult when someone calls in and until a replacement is found they have to work short.<br><br>NA-G stated on 10/4/17, at 9:12 a.m. on a daily basis a residents call light can take up to two hours to be answered because we are with other people. The residents get upset and are frequently incontinent. It happens more on the 4th floor. There used to be five aids scheduled on the 4th floor, which was difficult to meet the residents needs, but now they are only scheduling four nursing assistants. Since the health department entered the facility there are way more people up her helping, and we still can't get things done timely. Sometimes there are only three nursing assistants on the 4th floor and its "really really hard" and it has been this way last two months. The residents deserve more time to have their basic needs met. Staffing is so bad here in the evening residents are screaming and fighting. Management tells us were are staffed according | F 353 | | |

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to our census. NA-G stated it feels like neglect we are neglecting the residents, but it isn't on purpose.

NA-H stated on 10/4/17, at 9:55 a.m. residents whom are a check and change for incontinence they only get changed in the morning and afternoon, because that is all the staff had time to do. There are not enough staff to meet the resident needs.

ADON-C stated on 10/5/17, at 8:58 a.m. assessments required quarterly and when there is a change in condition, along with updates to the care plan, that are not getting done. ADON-C stated she was needed on the floor do to the lack of staff scheduled. We know they assessments and care plans need to be updated, but there is not enough time.

Anonymous staff interview (AS) stated on 10/5/17, 2:20 p.m. there are times that meals have to be delayed 30 minutes or more because there are not enough staff to bring residents into the dining rooms, help pass the meals or assist resident in eating. AS stated the floor staff are busy with other cares, answering call lights and they are short.

Review of the facility grievance log provided by the facility identified the following staffing and customer services concerns:
- 8/15/17 concerns regarding long wait times for medications
- 8/21/17 concerns regarding long wait times for cares
- 8/30/17 concerns regarding long wait times
- 8/30/17 concerns regarding staff attitude,

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wait times and residents wandering
- 9/4/17 customer service concerns
- 9/8/17 customer service concerns
- 9/11/17 concerns related to cares and time put to bed
- 9/15/17 concerns regarding wait times for pain medication
- 9/19/17 concerns related to incontinent products and cares
- 9/19/17 concerns related to call light time
- 9/28/17 concerns regarding care concerns
- 9/29/17 concerns regarding cares.

In an interview on 10/4/17, at 10:03 a.m. scheduling coordinator (SC)-A stated staffing is based, for the most part, on the census of each floor. SC-A stated each morning administration and nursing meet to review staffing, and changes are made depending on the needs of each floor. SC-A stated that she is not sure if there is a formula or how it is determined. SA-A further stated the facility hired an additional scheduler, to assist in replacements.

Review of the facility nursing/nursing assistant schedule, from October 1 - October 4th, 2017 identified the following staffing levels:

> 1st Floor: AM Shift 2 nurse and 3 nursing assistants, PM Shift 1 nurse and 3 nursing assistants, Night Shift 2 nurses (Sunday and Monday due to training) with one nurse Tuesday and Wednesday along with 2 nursing assistants (10/1/17 there were 20 residents on this floor)

> 2nd Floor: AM Shift 2 nurses and 3 nursing assistants, PM Shift 2 nurses and 2 nursing assistants, Night Shift 1 nurse and 2 nursing assistants. (10/1/17 there were 21 residents on

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this floor)

> 3rd Floor: AM Shift 1 nurse and 1 nursing assistant, PM Shift 1 nurse and 1 nursing assistant, Night Shift 1 nurse with no nursing assistant on Sunday night, however only had 1 nursing assistant Monday through Wednesday night. (10/1/17 there were 5 residents on this floor)

> 4th Floor: AM Shift 4 nurses Sunday and Monday, and 3 nurses Tuesday and Wednesday and 5 nursing assistants on Sunday, but only 4 nursing assistants on Monday through Wednesday, PM Shift 3 nurses and 6 nursing assistants (one a trainee), with only 4 nursing assistants on Monday and Wednesday, and 5 on Tuesday, Night Shift: 1 nurse and 3 nursing assistants. (10/1/17 there were 48 residents on this floor)

During an interview on 10/4/17, at 2:10 p.m. the executive director (ED) stated she was aware that staffing was not optimal, and attempted to schedule extra if there is a call in, which is not always possible. When asked how the facility had been attempting to correct the facility's staffing issues. ED stated that the facility has hired an additional scheduler, who's shifts over lap to help with call-in replacements throughout the day, but stated that the schedulers do not work on the weekends. The ED stated that the assistant director of nursing's (four in total) take weekend call, and have staff scheduling information with to fill weekend call-ins. The ED stated each morning (Monday - Friday) during "standup," management review the "allocation" of facility staff, so shortages and cares concerns can be addressed. ED stated that they try to schedule

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| F 353 | Continued From page 148<br>extra staff each day so that "call-ins" and "no-shows" so not to impact resident care. ED stated through quality assurance and staff input, the facility is working on employee retention and recruitment. ED stated that they are trying such things as employee snack cart, employee dress up theme days, monthly staff recognition, monthly birthday cake and getting a better system in managing time off requests of staff.<br><br>A facility policy for staff scheduling/staff coverage was requested, however not received. | F 353 | | |
| F 373<br>SS=J | 483.60(h)(1)-(3), 483.95(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT<br><br>483.60<br>(h) Paid feeding assistants-<br><br>(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if-<br><br>(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and<br><br>(ii) The use of feeding assistants is consistent with State law.<br><br>(h)(2) Supervision.<br><br>(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).<br><br>(ii) In an emergency, a feeding assistant must call a supervisory nurse for help. | F 373 | | 10/5/17 |

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| F 373 | Continued From page 149<br><br>(h)(3) Resident selection criteria.<br><br>(i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.<br><br>(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.<br><br>(iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.<br><br>483.95<br>(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.60<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R19) identified with swallowing difficulties received safe and appropriate assistance with eating. A non-trained paid feeding assistant/staff member, Human Resources (HR)-A, assisted with feeding a resident who had a history of aspiration pneumonia and a complicated feeding problem. R19 was observed coughing while being fed by HR-A. Even though nursing staff were directly across the table while this occurred, they did not intervene placing R19 at risk. The findings | F 373 | 1) R19 will be assisted with eating in a safe manner by licensed nurses, NARs, and speech therapists. R19 care plan and nursing assistant care delivery guide were updated with speech therapy recommendations. Meal ticket for R19 was updated to alert staff to refer to feeding instructions. Treatment record updated to have licensed staff (nurses) monitor through visual observation that feeding recommendations are being followed at breakfast, lunch, and dinner. | |

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| F 373 | Continued From page 150<br>constituted an immediate jeopardy (IJ) situation for R19, with the potential for serious harm, injury or death.<br><br>The facility also failed to ensure residents who were fed by a paid feeding assistants (PFA) were appropriately assessed to be fed by a PFA, and receive training through a state approved program for 2 of 2 (R19, R97) residents who were observed to be fed by a PFA. R97 did not have swallowing problems but needed staff assistance with eating.<br><br>The immediate jeopardy began on 10/04/17, at 8:12 a.m. when HR-A was observed to assist R19 with eating, who had a complicated feeding problem and was having difficulty swallowing. The executive director (ED), interim director of nursing (DON), director of clinical services (DOCS), assistant ED-A and ED-B were informed of the immediate jeopardy on 10/04/17, at 4:15 p.m.. The IJ was removed on 10/05/17, at 2:54 p.m., but non-compliance remained at the lower scope and severity of (D) isolated, with potential for more than minimal harm that is not Immediate Jeopardy.<br><br>Findings include:<br><br>During entrance interview on 10/01/17, at 12:16 p.m. with the adminstrator and the interim director of nursing (DON) both stated they did not have a paid feeding assistance program (PFA) to assist residents with eating.<br><br>R19's Admission Record undated indicated that he had dementia and dysphagia (difficulty swallowing). R19's Minimum Data Set (MDS) dated 09/08/17, indicated he needed extensive | F 373 | Specific education for R19 was provided to nurses and NARs regarding feeding instructions. Feeding instructions include provide alternating ½ spoonful of puree and ½ spoonful of thickened liquids and waiting for mouth to clear. Respiratory therapist completed a respiratory assessment on R19 on 10/4/17. Physician was updated on 10/4/17 regarding increased coughing at meal no new orders were received.<br>Immediate verbal education was provided to Employee 1 (LJ) that was assisting R19 with feeding and instructed that only licensed nurses and NARs are able to assist residents with eating. Employee was suspended pending the outcome of the investigation.<br>2) Team including nurse managers, speech therapy, dietary manager, registered dietician, DON, and ED reviewed all residents that required special feeding needs. Residents in facility were identified for potential difficulties with eating through visual assessment during meals. Two other residents were identified to have like concerns. R97 was assessed by speech therapy and occupational therapy for feeding technique on 10/4/17. R97 requires food to be cut in small pieces and food placed on left side. Resident meal ticket, Care plan and NAR care delivery guide were updated with recommendations. Resident B is going to be treated by speech therapy for ongoing treatment. Resident B has identified orders on 10/5/17 that resident is NPO. MD will be present next week for | |

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assistance of one with eating and had no swallowing disorders. R19's Nutritional Status Care Area Assessment (CAA) dated 09/13/17, indicated he required assistance with feeding at meals and had a need for special diet or altered consistency which might not appeal to resident. The CAA further indicated he received sufficient eating assistance.

A Discharge Summary Note dated 12/02/16, from North Memorial Medical Center, indicated he was hospitalized from 11/30/16 to 12/02/16. The Discharge Summary note identified he had aspiration pneumonia, and x-ray with bilateral infiltrates (something that has gotten in to the lungs from the outside. Any abnormal density will show up in the otherwise air filled lungs. Usually the infiltrate will mean pneumonia, or some sort of infection with edema/swelling that is in the lung).

R19's Nutrition Risk Care Plan dated 9/08/17, indicated he received a pureed diet with honey thickened liquids and needed total assistance to the dining room and reminded of meal times. The care plan did not list specific speech therapy recommendations.

Review of R19's diet card, undated, indicated he needed total assistance to be fed and received honey thickened liquids and a pureed diet. In addition, R19's nursing assistant care sheet, undated, indicated his liquids were honey consistency and he needed total assistance with eating with a note, "see ST [speech therapy] instruction."

R19's speech therapist note dated 8/02/17, indicated PT (patient) seen for skilled ST services

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evaluation. Care plan and NAR care delivery guide updated with new orders.
3) Education was provided to staff including leadership team, nurses, NARs, social service, dietary, maintenance, and human resources regarding only nurses with a current license, nursing assistants currently on the registry or speech therapists may assist residents to eat on 10/4/17 and 10/5/17. Education was provided to nurses and nursing assistants to include: residents with special feeding instructions will be indicated on the meal ticket to refer to the nutrition services binder which will be located on the juice cart in the dining room, and/or laminated card placed at the table. Staff is to stop feeding and report to nurse immediately if any excessive coughing, swallowing issues, or holding food in mouth. Education will be provided to all staff present in building on 10/4/17 and 10/5/17. Mandatory education regarding special feeding instruction program will be provided to all employees before they are able to work. Notification will be posted by timeclock to check with nurse manager to receive mandatory education prior to working. This education will be provided ongoing to new employees during orientation and annually to all staff. Feeding instructions will be reviewed by nurse manager and dietician quarterly and with significant changes in condition. Nurse managers will verify that feeding instructions are available in binders and laminated cards are available at meals – quarterly and with any changes.
4) Compliance of plan of correction will

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to address dysphagia and complete final session to receive discharge documentation. Therapist followed up with nursing staff regarding use of printed compensatory swallowing strategies to reduce aspiration risk. A 24-hour log updated for discontinuation of services due to inability to progress due to dementia and inability to follow cues. Nursing staff to implement use of compensatory swallowing strategies and monitor for ongoing signs and symptoms of aspiration.

A 24 Hour Status Report dated 8/02/17, indicated: "D/C [discontinue] from ST today continue puree/honey thick liquid diet. Printed strategies at patient's table to follow during meals."

The speech therapy instruction sheet indicated the following:
* Bite sizes should be 1/2 spoonful of puree
* Use spoon to give honey thickened fluids (1/2 spoon size)
*Allow patient to clear mouth completely before giving another bite
* Do not put more food in patient's mouth if he is still chewing
* If he begins coughing, do not give more food until coughing discontinues.

During observation on 10/01/17, at 12:12 p.m. nursing assistant (NA)-B was observed to give R19 a drink of his juice brining his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited for him to stop and then continued to give him a teaspoon full of his potatoes, and then a teaspoon of his pureed roast beef and he coughed again. At

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be completed through meal audits of all meals. Audits to include visual observation of compliance with feeding instructions, compliance with placement of feeding recommendations in binder in dining room and laminated cards placed at table, and appropriate staff assisting with feeding. Audits will be completed by DON or designee on all floors for every meal for 2 weeks and then 3 times a week for a period of 3 months to ensure compliance. Audits will be reviewed monthly at QAPI. QAPI members to determine frequency of audits after review of findings. DON and ED responsible for compliance.

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| **GOLDEN VALLEY REHABILITATION AND CARE CENTER** | **7505 COUNTRY CLUB DRIVE**<br>**GOLDEN VALLEY, MN 55427** |

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| F 373 | Continued From page 153<br>12:19 p.m. she fed him a level teaspoon full of his mashed potatoes and he coughed again, then NA-B stated to R19 'It's ok" and gave him a drink of his juice from his cup. At 12:20 p.m. surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the instructions that were on the window sill of the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive 1/2 teaspoons of food and liquids at a time. NA-B then took the teaspoon at the table and placed in his honey thickened juice and proceeded to feed him 1/2 teaspoons of his food and beverages and his coughing had decreased.<br><br>During observation 10/04/17, at 8:12 a.m. HR-A was observed in the first floor dining room assisting R19 with eating. R19 had scrambled eggs, pureed sausage, oatmeal and honey thickened cranberry juice. At the same table directly across from HR-A, sat assistant director of nursing (ADON)-B whom was assisting R134 with eating. HR-A gave R19 a level teaspoon full of pureed sausage and then immediately gave a heaping teaspoonful of his oatmeal, without first waiting for R19 to swallow the spoonful of pureed sausage before immediately giving a heaping spoonful of oatmeal to R19. R19 immediately started to cough, loudly turning his head away from HR-A to the right. HR-A stopped feeding him and rubbed his back and waited for him to stop coughing. HR-A then brought R19's glass of honey thickened cranberry juice just below his chin and began spoon feeding R19 three spoonfuls of thickened juice, one after another without first waiting for R19 to swallow each bite. HR-A fed R19 a full teaspoon of thickened juice, | F 373 | | |

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not a half teaspoon as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his pureed sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A while she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was not following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scrambled eggs, pureed sausage, and half of his oatmeal and 3/4 of his honey thickened cranberry juice. ADON-B left the same table HR-A was assisting R19 and NA-M then sat down to assist R134 across the same table R19 was sitting at. At approximately 8:25 a.m. SLP-A entered the dining room, and surveyor informed her of the above observation. HR-A was removing R19's clothing protector and SLP-A immediately walked up to the table and instructed HR-A she should have been following her recommendations of bite sizes which is 1/2 spoonful of liquids and food. HR-A then stated that NA-M had just informed her of the SLP instructions and she had stopped feeding R19.

During interview 10/04/17, at 9:22 a.m. HR-A stated she had been working at the facility since 03/07/17, and became a NA in 2005, her NA certificate had expired in 2008, and she had not

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renewed her certificate. HR-A stated she assists with feeding when they are short staffed and had also assisted another resident (R97) on the fourth floor. HR-A stated she does not need to feed the resident on fourth floor but just makes sure she does not spill her food while she is feeding herself.

During interview on 10/04/17, at 12:20 p.m. NA-K stated she knows that when feeding R19 they are to give small amounts of food and then give liquids to make the food go down. NA-K stated she does not know if there was any size amounts of the food or liquids and he had a tendency to cough while being fed. She indicated his ticket says instructions on how he should be fed and it should also be on his care plan.

During interview on 10/04/17, at 12:25 p.m. licensed practical nurse (LPN)-D stated she was not aware of any feeding recommendations for R19 and added, "What I don't know I can't tell you!"

During interview on 10/04/17, at 12:42 p.m. SLP-A stated she had written up the instructions with his plan of care, and had made these recommendations for R19 on 7/24/17, and trained staff that assisted with feeding him. The SLP indicated she left the feeding instructions at the table where R19 ate and the instructions would disappear, so she would make new cards and leave them again at his table. SLP-A stated she also told the interim nurse manager during this time, but she no longer works at the facility. In addition, the SLP-A stated she wrote these recommendations on the 24 hour communication board for all staff to see. The SLP-A further stated R19 will cough while eating and she

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| F 373 | Continued From page 156<br>recommended a swallow evaluation awhile ago, but did not think the facility followed through on her recommendation. She relied heavily on the staff to follow through with her recommendations since he was at such high risk for aspiration and it was vital to follow through with SLP's recommendations. The SLP-A stated when she feed R19 1/2 teaspoons of his food and liquids he coughs much less and it reduced his risk of aspiration.<br><br>During interview on 10/04/17, at 1:01 p.m. assistant director of nursing (ADON)-B stated, "I don't know anything about a swallow evaluation." ADON-B added she had been working on the floor at the facility for six weeks which was prior to the SLP recommendation and indicated she could call his guardian. In addition, ADON-B stated she found out about R19's recommendations last Friday when she overheard a NA instruct another NA about how to feed him. ADON-B further indicated he gets pureed food and that you have to give it to him slowly and was not aware of any portion size but to just feed him slowly.<br><br>During interview on 10/04/17, at 3:06 p.m. ADON-B stated that administration told her that HR-A was a certified nursing assistant so she did not say anything to her about not assisting R19. ADON-B added she not realize she (HR-A) was not following his feeding instructions but once she found out she was not following his instructions she contacted respiratory therapy to do an evaluation and took his vital signs which were with in normal limits. In addition, ADON-B stated she placed a call out to R19's primary physician informing him of the facility not following the SLP-A feeding instructions and had not heard | F 373 | | |

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back from him. Further, ADON-B stated R19's instructions for feeding were not at the table during lunch today and a downfall they have at the facility is they keep rotating staff from different floors so they do not know the residents.

During interview on 10/4/17, at 3:32 p.m. NA-O stated R19 had coughed a lot while eating, was slow to eat, received thickened liquids and pureed food. NA-O stated they use a four ounce glass to assist R19 to drink. If R19 had coughing while using the glass with increased coughing, he would use a spoon for the thickened liquids and give a full teaspoon of fluid. Previously (approximately 3 months ago) there were written directions on the table that directed staff to use a spoon for fluids but these directions were removed from the table. They resumed to feed R19 as they did previously either with a glass or spoon, and monitor his response. NA-O was unaware he needed to give R19 half teaspoon of fluids and not use a glass.

During interview 10/04/17, at 3:42 p.m. NA-L stated an educator from the facility instructed her on R19's SLP-A recommendations but she stated, "I told her as soon as you walk away I won't remember what you told me. She didn't say anything and had me sign a paper saying I was educated." NA-L then stated, "I had not fed him since he was on his new diet."

On 10/5/17, at 8:07 a.m. the director of regional operations (DORO) stated HR-A was not directed by any management team member to assist with feeding and she had never done any type of feeding before; however, DORO then stated HR-A had been misleading the facility by telling facility staff members she was a nursing

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| F 373 | Continued From page 158<br>assistant. Although DORO identified this, there was no indication any management staff had checked with HR-A if her nursing assistant certification was current, even though they identified HR-A communicated to them she was a nursing assistant.<br><br>During interview 10/5/17, at 2:15 p.m. NA-Q stated she received new education and the staff needed to check the meal ticket for any special feeding instruction and directions that referred to the black book would be located on the beverage cart. A nurse needed to be in the dining room prior to staff serving resident and if anyone started coughing or choking they were to alert the nurse.<br><br>Interview on 10/5/17, at 2:17 p.m. licensed practical nurse (LPN)-F stated she had been educated on the new process regarding residents who have special diet. The ticket on the table would have the instructions and if needed would indicate to check the black book which would be located on the beverage cart. Nurse needed to be in the dining room prior to serving and supervise staff and assist if there were any issues with coughing or choking. Only trained staff can assist with feeding residents.<br><br>The immediate jeopardy that began on 10/4/17, at 8:12 a.m. was removed on 10/5/17, at 2:54 p.m. when it could be verified by observation, document review, and staff interview, the facility had educated dietary, ST and nursing staff of who could and could not feed residents, that a nurse needed to be in the dining room when residents were eating, where individual resident swallowing guidelines were located in the dining room, and what guidelines to follow to assist R19 and R97 to | F 373 | | |

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eat. The facility checked other resident with swallowing guidelines to ensure their programs were being followed and updated R19 care plans along with other residents who were at risk.

Although R19 had a history of aspiration pneumonia and was at risk for aspirating the facility failed to follow the SLP-A specific instructions while feeding R19, and ensure paid feeding assistants were appropriately trained. In addition, ADON-B and NA-M were directly across the table while HR-A was feeding R19 incorrectly, and made no attempts to stop or intervene while this occurred.

A policy was requested for following SLP recommendations but was not provided.

R97's undated admission record, identified diagnoses of cerebral vascular accident (CVA), aphasia (unable to communicate) and hemiplegia (paralysis of half of the body). R97's annual MDS dated 7/7/17, identified she was severely cognitively impaired, and needed extensive assistance with eating.

The Nutrition Risk Data Collection and Assessment dated 7/7/17, identified R97 had a regular diet, with nutritional supplements. She had no problems with chewing or swallowing and only needed staff assistance as needed. An updated nutrition progress note dated 10/4/17, identified speech language pathology

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| F 373 | Continued From page 160<br>recommended to cut resident's food into bite size pieces and place food to the left side of resident and assist to feed as needed.<br><br>R97's care plan updated 10/4/17, identified a problem with nutrition, which directed staff to assist with meals as needed after total set-up and cut food into bite size pieces and place food on left side.<br><br>During interview 10/04/17, at 9:22 a.m. HR-A stated she had been working at the facility since 03/07/17, and became a NA in 2005 but her NA certificate had expired in 2008, and had not renewed her certificate. HR-A stated she assisted with feeding when facility was short staffed and had assisted R97 on the fourth floor. HR-A stated she did not need to feed this resident but just made sure she did not spill her food while R97 was feeding herself.<br><br>During interview on 10/4/17, at 12:20 p.m. NA-G who worked on the forth floor stated (HR-A) came up to the 4th floor to help with dining "frequently" assisting R97 to eat, however, she was unable to be more specific regarding the time frame of "frequently." This interview conflicted with HR-A's interview that she only makes sure R97 did not spell her food, and did not feed her. | F 373 | | |
| F 412 SS=D | 483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS<br><br>(b) Nursing Facilities<br><br>The facility-<br><br>(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this | F 412 | | 11/13/17 |

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| F 412 | Continued From page 161<br>part, the following dental services to meet the needs of each resident:<br><br>(i) Routine dental services (to the extent covered under the State plan); and<br><br>(ii) Emergency dental services;<br><br>(b)(2) Must, if necessary or if requested, assist the resident-<br><br>(i) In making appointments; and<br><br>(ii) By arranging for transportation to and from the dental services locations;<br><br>(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a dental referral was followed through to address dental concerns for 1 of 1 residents (R162) reviewed for dental concerns.<br><br>Findings include:<br><br>R162's annual Minimum Data Set (MDS) dated 5/20/17, identified R162 had no cognitive impairment and required extensive assistance with personal hygiene. R162's Admission Record, undated, identified R162's payer source to be Medicaid. The Admission Record further indicated he had been admitted on 05/09/17.<br><br>R162's Nutrition Risk Data Collection dated | F 412 | 1. R162 dental referral has been completed. R162 has been reassessed and referral for denal services has been made.<br>2. Residents residing in the facility have the potential to be affected. Residents have been reviewed for last routine dental service date and need for further follow up for dental services.<br>3. LN Staff and Social Services have been re-educated on the facility’s dental policy and procedure to include referrals for dental care. Caring Partners will interview residents weekly on dental needs and report findings to the DON and ED for follow up. Residents with dental referrals will be tracked on the clinical | |

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| F 412 | Continued From page 162<br>08/16/17, identified R162 had no chewing or swallowing problems.<br><br>During interview on 10/02/17, at 12:36 p.m. R162 stated he had lots of problems with cavities and had a filling that had fallen out within the last year. R162 stated he went to the dentist last summer and had all of his teeth done, but since then has had problems with cavities and a lost filling. R162 stated when he admitted to the facility he had requested to see a dentist.<br><br>Review of R162's medical record indicated that on 05/12/17, he had requested a referral with Door Step Healthcare Services for dental treatment.<br><br>A Golden Valley Rehab & Care Center Communication Result Report dated 05/23/17, at 1:57 p.m. indicated a referral was sent to Doorstep and confirmation of receiving the referral from Doorstep was received on 05/23/17, at 1:58 p.m..<br><br>During interview on 10/03/17, at 8:46 a.m. medical records director (MR)-A stated R162 makes his own decisions and he signed up for dental services when he admitted. MR-A then indicated a referral was faxed on 05/23/17, and that she had confirmation they received the fax. MR-A stated the dental service comes out monthly and did not know why he was not seen. In addtion, MR-A stated once the referral is sent to Doorstop they leave it up to them to schedule the appointment and that no one in the facility tracks if they are seen or not after the referral is sent.<br><br>Although R162 addressed concerns of his teeth | F 412 | follow up tool and during the facility's clinical meeting processes until resolution occurs.<br>4. The Units Social Worker will track annual dental service date, as well as dates of referrals made. The Director of Social Services or designee will be responsible for auditing compliance of the policy and facility follow through, completing weekly audits of dental service dates and follow up on referrals of 5 residents per week. Audits will be completed weekly for 4 weeks then monthly times 2 months . Results of the audits will be forwarded to the QAPI committee for opportunities of continued quality improvement for 3 months.<br>DON to monitor compliance | |

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| F 412 | Continued From page 163<br>the facility failed to follow thru to ensure he was seen by a dentist as he had requested upon admission on 05/23/17, almost five months later. | F 412 | | |
| F 425 SS=D | 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure insulin was administered in accordance with manufacturer instructions to ensure complete dosing for 1 of 1 residents (R31) observed to receive insulin. In addition, the facility failed to ensure opened insulin's were dated when opened to prevent potential administration after expiration for 2 of 2 residents (R200, R84) observed to have undated insulin available for administration in the medication cart(s).<br><br>Findings include:<br><br>INSULIN ADMINISTRATION:<br><br>R31's signed physician orders dated 9/25/17, identified an order for a Lantus Solostar Pen (long | F 425 | R31 medication regimen review was completed and continues with use of insulin via insulin pen. Insulin will be administered per manufacturer recommendations. R200 and R84 insulin was noted for record of date opened on device.<br>2. The facility has identified residents that are currently diabetic and utilizing insulin regimen. Medication carts will be audited for date open documented on insulin pens. Reminder cards were placed on med carts to remind nurses to prime pens prior to administering insulin.<br>3. Licensed staff will be assigned to complete a nursing competency for administration of insulin with pens with education nurse or designee. The facility | 11/13/17 |

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| F 425 | Continued From page 164<br>acting insulin used to reduce blood sugar levels) and directed staff to, "Inject 71 units [subcutaneous; under the skin] twice daily," for management of his diabetes (disease causing increased blood sugar levels).<br><br>A BD (Becton, Dickson and Company) Autoshield Duo Safety Pen Needle Instructions for Use insert dated 6/2014, identified instructions for how to attach the needle to an insulin pen. The instructions directed to screw the needle onto the pen, remove the cover and then, "Check if the Pen Needle is attached correctly - dial 2 units, point the pen up and press the thumb button." Further, the instructions identified to repeat if liquid does not appear at the needle tip.<br><br>During observation of insulin administration on 10/4/17, at 6:54 a.m. licensed practical nurse (LPN)-D removed a Lantus insulin pen from a mobile cart on the first floor. The pen was undated when it had been opened and first used, and LPN-D stated it was, "a good question," however, added R31 used it quickly due to a high dose. LPN-D removed a BD Pen Needle and attached it to the device, then turned the dial (used to determine the dose) up to 71 units and showed the surveyor. LPN-D then closed R31's medication administration record (MAR) and began to walk over to R31 to administer the medication. LPN-D was stopped by the surveyor and questioned about if the insulin pen had been primed. LPN-D stated, "you do not prime," the needle with insulin before administration as the needle was considered sterile. LPN-D then administered the insulin using the pen with an un-primed needle to R31 in his room.<br><br>Immediately following the administration, LPN-D | F 425 | storage of dating medications, biologicals, syringes and needles policy has been reviewed. The Education nurse will verbally review the policy with all current Nurses, emphasizing on the importance of recording the date the insulin was opened and priming of insulin pens.<br>4. Insulin administration audits will be completed on 5 residents a week for 4 weeks then monthly times 2 months, on all units, by DON or designee. The Director of Nursing or designee will complete audits of Medication carts weekly for compliance of dating of insulin for 4 weeks then monthly times 2 months. Results of the audits will be forwarded to the QAPI committee for opportunities of continued quality improvement for 2 months.<br><br>DON to monitor compliance. | |

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was interviewed and stated she felt there was no need to prime the needle before insulin administration, as there was no air inside the insulin pen. LPN-D reviewed the safety needle instructions including priming of the needle with the surveyor, and stated, "that's what I did."

When interviewed on 10/4/17, at 11:23 a.m. assistant director of nursing (ADON)-A stated insulin pen needles should be primed before being used to remove air from the needle to, "make sure they're [residents] getting the correct dosage."

During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated a needle attached to an insulin pen should be primed with a, "two unit air shot," before being used on a patient.

A facility Insulin Injection policy dated 7/2015, identified a subject to safely administer insulin and listed a procedure for staff to follow using an insulin vial with syringe, however, lacked any directions or procedures for staff to use when injecting insulin using a flexpen and attached needle.

LACK OF INSULIN DATING:

On 10/1/17, at 10:50 a.m. the Second Floor South medication cart was reviewed with licensed practical nurse (LPN)-H. The top drawer of the cart was opened with four opened, uncapped vials of insulin inside. One vial of Novolin R (short acting insulin, good for only 42 days after being opened) was approximately 3/4 full, however, lacked any labeling to identify which resident had

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| F 425 | Continued From page 166<br>been using it, or when it was opened. Further, an additional vial of Novolog (short acting insulin) was approximately 1/2 full and had no label or writing on the vial to demonstrate when it had been opened or which resident was using it. LPN-H reviewed both vials and stated she was unaware how long they had been opened for, nor which resident received them adding, "these can just be tossed."<br><br>A vial of Novolin N (an intermediate acting insulin) was labeled for R200 with approximately 1/2 of the insulin remaining inside. The label had spacing on a yellow colored sticker to record the, "date opened," and, "exp. [expiration] date," however, both of these spaces were left blank. There was no recorded, visible date on the vial to identify when it had been opened. LPN-H stated she was, "not sure," when they were opened. In addition, two separate opened Lantus flexpen(s) were stored in the cart and also labeled for R200. LPN-H observed the pens and stated, "nothings labeled," when they were opened.<br><br>Further, two additional separate Lantus flexpens were inside and labeled for R84. One of the pens was dated when it had been opened, however, the other was undated and lacked any markings to demonstrate when it had been removed from the refrigerate and opened. LPN-H stated it, "need to be thrown," and staff should be recording dates on all insulin when they are opened as, "they expire in a month."<br><br>When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated insulin, "needs to be dated," when opened as insulin expired after a set period of time. | F 425 | | |

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| F 425 | Continued From page 167<br>During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated insulin containers should be dated when opened to follow recommended storage guidelines and so staff, "know how long their good for."<br><br>A facility Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy dated 10/16, directed staff to follow manufacturer/supplier guidelines for expiration dates for opened medications including to, " ... record the date opened on the medication container when the medication has a shortened expiration date once opened." | F 425 | | |
| F 431 SS=E | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and | F 431 | | 11/13/17 |

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| F 431 | Continued From page 168<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure transdermal narcotic patches were disposed of in methods to help prevent diversion. This practice had potential to affect 2 of 2 residents (R188, R161) with current orders for transdermal patches in the facility. Further, the facility failed to ensure narcotic | F 431 | 1. Facility Destruction of Controlled Drugs policy states staff are to destroy transdermal patches following removal, with two licensed nurses signing in the medication record and to dispose by flushing via sewer system. R188 has order for Fentanyl 50mcg/hr to be applied every 72 hours. Order has instruction to | |

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reconciliation was completed in accordance with policies and procedures to ensure rapid detection of potential diversion on 3 of 3 medication carts (4th Floor, 3rd Floor, 2nd Floor) reviewed during the survey. This had potential to affect 38 of 38 residents with current orders for controlled substances on these affected floors.

Findings include:

A facility Destruction of Controlled Drugs policy dated 7/2015, directed staff to destroy used transdermal patches (i.e. Fentanyl [a potent narcotic medication]) following removal from a resident with, "Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record [MAR]." Further, the policy identified flushing transdermal patches was the, "preferred," method unless it was prohibited, then staff should be cutting the patches in half and placing them into a, "drug buster" system.

An undated Fentanyl Patch listing was provided which identified R188 and R161 had current orders for Fentanyl transdermal patches in the facility.

On 10/1/17, at 10:50 a.m. the Second Floor South medication cart was reviewed with licensed practical nurse (LPN)-H. The cart contained a second metal container with was locked with a key. The container was opened and several narcotic medications were housed inside including several opened boxes of Fentanyl transdermal patches. LPN-H described the process for removing and disposing of used transdermal patches, stating staff were supposed to, "have somebody watch," when used patches

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fold and flush patch down toilet following removal, as well as two nurses must witness and record initials when completed. Facility controlled drug policy outlines section of ongoing inventory of controlled drugs at each shift. The section instructs staff to document all controlled medications, including schedule II, III, IV and V, had been counted by the off-going and on-coming nurse or TMA. R123 Oxycodone count has been reconciled.
2. Residents with transdermal patches, i.e Fentanyl, have been identified. All identified medication administration records have been reviewed for instruction to fold and flush patch down toilet following removal, as well as two nurses must witness and record initials when completed. All medication carts/controlled drugs have been counted per Director of Nursing and Unit Nurse Manager, for an all house reconciliation.
3. The facility has reviewed the policy for destruction of controlled drugs. Nurse Educator will review facility destruction of controlled drug policy emphasizing the destruction of transdermal patches and the ongoing inventory of controlled drugs at each shift, with each Nurse and TMA.
4. Nurse Managers will conduct medication administration/removal of transdermal patches audit on weekly basis x4 weeks then monthly for 2 months for those residents that have fentanyl patches. The Director of Nursing or designee will conduct controlled drug reconciliation, with floor staff, on a weekly basis, on each medication cart. Audits

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| F 431 | Continued From page 170<br>are removed and disposed of. LPN-H stated when she removed patches, she placed them, "in the sharps container [attached to medication cart, able to be accessed using scissors and cutting]." Further, LPN-H stated she had changed a patch for R188 that morning (10/1/17), however, added she did not have anyone else watch it as nobody was available at the time.<br><br>R188's 10/2017 MAR was reviewed with LPN-H. The MAR identified an order for Fentanyl 50 mcg/hr (micrograms per hour) to be applied every 72 hours. Further, the MAR had directions of, "Fold and flush patch down toilet following removal / Two nurses must witness," and provided spacing for two nurses to record their initials when completed. However, these spaces were left blank with no initials recorded.<br><br>When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated used transdermal patches should be removed with two nurses present and disposed to, "via sewer." ADON-A stated removing patches without two staff and disposing of them in a sharps container was, "not acceptable," and the nurse, "needs education."<br><br>During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated the facility policy was for two nurses to witness and destroy the used transdermal patches via sewer as there was, "left over drug on the patch." CP-A stated the nurse disposing of the patch in the sharps container and removing on her own, "didn't follow the policy."<br><br>NARCOTIC RECONCILIATION: | F 431 | will be completed weekly for 4 weeks then monthly for 2 months. Results of the audits will be forwarded to the QAPI committee for opportunities of continued quality improvement for 3 months.<br>DON to monitor compliance | |

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A facility Controlled Drugs policy dated 7/2016, identified a directive to, "assure that all Centers have procedures in place to safeguard the ordering, receipt, administration, storage and destruction of controlled drugs." The policy outlined a section of, "Ongoing Inventory of Controlled Drugs at Each Shift ...," and directed staff to document all controlled medications, including schedule II, III, IV, and V, had been counted by the off-going and on-coming nurse or trained medication aide (TMA).

Further, an additional Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy dated 10/16, identified a section labeled, "Controlled Substances Storage," and directed, "Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security."

On 10/1/17, at 9:49 a.m. the South 4th Floor medication cart was reviewed with licensed practical nurse (LPN)-G. The cart was locked with a physical key with an additional metal compartment inside which contained oral narcotic medications. LPN-G opened the locked metallic compartment and stated she, "[had] not signed out a few," of the narcotics she gave this morning during her 8 a.m. medication pass. LPN-G would not complete a narcotic count with the surveyor before signing them out. When completed, LPN-G and the surveyor counted the narcotics inside the metallic compartment. LPN-G stated R123 should have 59 remaining oxycodone pills aloud, however, one had been removed from the middle of the package and only 58 pills remained. LPN-G stated she, "did not notice that," when counting with the off-going nurse that morning

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and added, "I don't know what happened." No further narcotic counts were incorrect on the medication cart. LPN-G reviewed for process for counting the medication carts with the surveyor, and stated the nurses sign off each time they count on a flowsheet contained in a binder. These flowsheets consisted of six columns with each nurse signing off for each shift. A total of six signatures were required to satisfy the flowsheet and provide evidence the medication cart had been counted. The following was identified:

September 2017:
9/1/17 - three of the six spaces were left blank,
9/2/17 - all six spaces were left blank,
9/3/17 - all six spaces were left blank,
9/4/17 - five of the six spaces were left blank,
9/5/17 - one of the six spaces were left blank,
9/8/17 - two of the six spaces were left blank,
9/10/17 - three of the six spaces were left blank,
9/11/17 - all six spaced were left blank,
9/12/17 - all six spaces were left blank,
9/13/17 - three of the six spaces were left blank,
9/14/17 - two of the six spaces were left blank,
9/15/17 - three of the six spaces were left blank,
9/16/17 - all six spaces were left blank,
9/17/17 - five of the six spaces were left blank,
9/18/17 - two of the six spaces were left blank,
9/19/17 - two of the six spaces were left blank,
9/20/17 - two of the six spaces were left blank,
9/21/17 - four of the six spaces were left blank,
9/23/17 - one of the six spaces was left blank,
9/24/17 - three of the six spaces were left blank,
9/25/17 - one of the six spaces was left blank,
9/26/17 - three of the six spaces were left blank,
9/28/17 - three of the six spaces were left blank,
9/29/17 - three of the six spaces were left blank and;
9/30/17 - two of the six spaces were left blank.

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In total, the cart had five instances when the cart had not been documented as being counted for an entire day. When interviewed immediately following this review, LPN-G stated she was unsure if the cart had not been counted, or if it had just not been documented adding, "it is not right." LPN-G stated it was important to count the medication carts each shift as, "medication might be missing."

The narcotic count flowsheets were provided for the remaining medication cart(s) on the 4th Floor and identified the following:

4th Floor "Middle" for September 2017:
9/1/17 - two of the six spaces were left blank,
9/3/17 - two of the six spaces were left blank,
9/4/17 - two of the six spaces were left blank,
9/5/17 - two of the six spaces were left blank,
9/10/17 - three of the six spaces were left blank,
9/11/17 - three of the six spaces were left blank,
9/13/17 - two of the six spaces were left blank,
9/17/17 - two of the six spaces were left blank,
9/18/17 - two of the six spaces were left blank,
9/21/17 - two of the six spaces were left blank,
9/22/17 - two of the six spaces were left blank,
9/26/17 - five of the six spaces were left blank,
9/27/17 - three of the six spaces were left blank,
9/28/17 - three of the six spaces were left blank,
9/29/17 - three of the six spaces were left blank and;
9/30/17 - one of the six spaces was left blank.

4th Floor "North" for September 2017:
9/1/17 - one of the six spaces was left blank,
9/2/17 - four of the six spaces were left blank,
9/3/17 - four of the six spaces were left blank,
9/4/17 - one of the six spaces was left blank,

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9/5/17 - three of the six spaces were left blank,
9/6/17 - three of the six spaces were left blank,
9/7/17 - five of the six spaces were left blank,
9/8/17 - three of the six spaces were left blank,
9/9/17 - two of the six spaces were left blank,
9/10/17 - five of the six spaces were left blank,
9/11/17 - three of the six spaces were left blank,
9/12/17 - all six spaces were left blank,
9/13/17 - three of the six spaces were left blank,
9/14/17 - two of the six spaces were left blank,
9/15/17 - five of the six spaces were left blank,
9/16/17 - three of the six spaces were left blank,
9/17/17 - two of the six spaces were left blank,
9/19/17 - two of the six spaces were left blank,
9/21/17 - four of the six spaces were left blank,
9/23/17 - three of the six spaces were left blank,
9/24/17 - three of the six spaces were left blank,
9/25/17 - one of the six spaces was left blank,
9/26/17 - two of the six spaces were left blank,
9/27/17 - two of the six spaces were left blank,
9/28/17 - five of the six spaces were left blank,
9/29/17 - five of the six spaces were left blank and;
9/30/17 - three of the six spaces were left blank.

On 10/1/17, at 10:33 a.m. the 3rd Floor South medication cart was reviewed with LPN-B who reviewed the process for counting and reconciling narcotic medications. LPN-B stated narcotics were counted, "during shift change," and recorded on flowsheets kept in a binder. These flowsheets were reviewed and consisted of the same format used on the 4th Floor cart(s) and identified the following:

September 2017:
9/2/17 - one of six spaces was left blank,
9/3/17 - one of six spaces was left blank,
9/9/17 - one of six spaces was left blank,

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| F 431 | Continued From page 175<br>9/17/17 - one of six spaces was left blank,<br>9/18/17 - one of six spaces was left blank,<br>9/19/17 - one of six spaces was left blank,<br>9/22/17 - one of six spaces was left blank,<br>9/23/17 - one of six spaces was left blank,<br>9/24/17 - one of six spaces was left blank,<br>9/27/17 - one of six spaces was left blank and;<br>9/29/17 - one of six spaces was left blank.<br><br>When interviewed immediately following this review, LPN-B stated staff must had, "forgot to sign off," on the counts being completed adding, "they [open spaces] should be filled in." LPN-B stated it was important to count and document the narcotic count each shift as, "that's how we know the count is correct," and nothing was missing. Further, LPN-B and the surveyor completed a count of the narcotics in the medication cart and found it to be correct.<br><br>On 10/1/17, at 10:50 a.m. the 2nd Floor South medication cart was reviewed with LPN-H who reviewed the process for counting and reconciling narcotic medications. LPN-H stated the narcotics were counted between each shift exchange, and both nurses were to sign the narcotic counting flowsheets contained in a binder on the cart. These flowsheets were provided and identified the following:<br><br>September 2017:<br>9/2/17 - one of the six spaced were left blank,<br>9/3/17 - four of the six spaces were left blank,<br>9/4/17 - two of the six spaces were left blank,<br>9/5/17 - one of the six spaces was left blank,<br>9/8/17 - two of the six spaces were left blank,<br>9/9/17 - one of the six spaces was left blank,<br>9/17/17 - two of the six spaces were left blank,<br>9/18/17 - two of the six spaces were left blank, | F 431 | | |

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| F 431 | Continued From page 176<br>9/19/19 - one of the six spaces was left blank,<br>9/21/17 - one of the six spaces was left blank,<br>9/22/17 - two of the six spaces were left blank<br>9/23/17 - three of the six spaces were left blank and;<br>9/26/17 - one of the six spaces was left blank.<br><br>When interviewed immediately following this review, LPN-H stated she was unsure why nurses had not signed the flowsheet to demonstrate they had counted the narcotics adding, "people maybe forgot to sign." Further, LPN-H stated it was important to count and sign the flowsheet as nurses coming on are, "taking credit the count is right," and so it could be tracked who had access to the medications inside.<br><br>The narcotic count flowsheets were provided for the remaining medication cart(s) on the 2nd Floor and identified the following:<br><br>2nd Floor "North Cart" for September 2017:<br>9/2/17 - one of the six spaces was left blank,<br>9/5/17 - one of the six spaces was left blank,<br>9/6/17 - one of the six spaces was left blank,<br>9/7/17 - one of the six spaces was left blank,<br>9/8/17 - two of the six spaces were left blank,<br>9/9/17 - one of the six spaces was left blank,<br>9/10/17 - one of the six spaces was left blank,<br>9/11/17 - five of the six spaces were left blank,<br>9/12/17 - four of the six spaces were left blank,<br>9/13/17 - two of the six spaces were left blank,<br>9/14/17 - three of the six spaces were left blank,<br>9/19/17 - one of the six spaces were left blank,<br>9/20/17 - one of the six spaces were left blank,<br>9/21/17 - five of the six spaces were left blank,<br>9/22/17 - two of the six spaces were left blank,<br>9/23/17 - one of the six spaces was left blank,<br>9/29/17 - one of the six spaces was left blank | F 431 | | |

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| F 431 | Continued From page 177<br>and;<br>9/30/17 - two of the six spaces were left blank.<br><br>A facility provided Month End Operations Report dated 10/4/17, identified 38 different residents had controlled substances stored amongst the three reviewed medication carts.<br><br>When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated the medication cart narcotics should be counted between each shift and documented on the flowsheet(s) so, "you know which nurse is responsible for the narcotics should anything go missing."<br><br>During interview on 10/5/17, at 12:07 p.m. the consulting pharmacist (CP)-A stated she completes audits on the medication carts, "periodically," and noticed back in June 2017, the narcotic counts were not being signed consistently. CP-A stated on her most recent audit, which had been completed less than a month ago, she again noticed "isolated issues" with the narcotic counts not being recorded. CP-A stated her audit results were reviewed with the interim director of nursing (DON) at the time, and also placed in a report for the facility on their website, however, added it was the facility's responsibility to review them. Further, CP-A stated staff should, "follow procedures" and ensure they are documenting each narcotic count. | F 431 | | |
| F 441 SS=F | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program. | F 441 | | 11/13/17 |

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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| F 441 | Continued From page 179<br>circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, and analysis of infections to prevent potential spread to other persons which had the potential to affect 94 current residents, staff and visitors to the facility. The facility failed to ensure they had developed a water-management program to identify risks and develop policy to prevent Legionella exposure, which had potential to affect all 94 current residents of the facilty. Further, the facility failed to ensure a community-based glucometer was cleansed in accordance with manufacturer guidelines to prevent cross contamination of | F 441 | R31 will have blood sugar monitored with a glucometer that has been sanitized prior to and after use following facility policy for cleaning. R121 will have dressing changed per order and following infection control standards for dressing changes including appropriate hand hygiene during treatment. Facility will complete surveillance, tracking, and trending of infections in the facility. Infection rates will be calculated monthly. Infection control nurse will monitor infections throughout the month for trends and need for interventions. Facility will develop a water management program to identify the risks | |

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| F 441 | Continued From page 180<br>blood-borne pathogens for 2 of 2 residents (R31, R89) observed during their blood glucose monitoring, which had the potenital to affect 8 residents on the first floor with current blood glucose monitoring orders. In addition, the facility failed to ensure staff infection control practices were being implemented during a dressing change for 1 of 1 residents (R121) observed during wound care. This had the potential to affect all 94 residents in the facility.<br><br>Findings include:<br><br>INFECTION CONTROL PROGRAM:<br><br>On 10/3/2017, in the afternoon, the assistant director of nursing (ADON)-C provided a three-ringed binder containing the facilty's infection control monitoring program. The binder included month divider tabs, and upon inspection, there were documents filed only under August and September 2017. Review of the materials identified the following:<br><br>September 2017:<br>A Monthly Line Listing Report/Monthly Healthcare Associated Infection Incident Rate worksheet was filled with sixteen (16) infection line listings, which identified, among other items: resident, room number, type of infection, onset date, if a culture was done, type of antibiotic and start date, and if the infection was acquired in house or not. There was an overall infection rate (3.13.%) calculated for September 2017, however, but no rate specific to site or type of infection, for example urinary tract, eye, respiratory or gastro-intestinal. Additionally under the September tab were four "infection Surveillance Worksheets" which corresponded to line items on the report, and | F 441 | and prevent legionella exposure.<br><br>Residents in the facility who require blood glucose monitoring and also residents who require dressing changes have the potential to be affected.<br><br>Licensed nurses will be re-educated on cleaning of glucometer per facility policy. LNs will also receive education regarding infection control procedures during dressing changes including hand hygiene. Facility will contract with agency to provide water management to reduce risk and prevent legionella exposure. LNs will receive education on infection control program to track and trend infections to prevent potential spread of infection to other residents, staff, and visitors.<br><br>DON or designee will complete observation of 5 blood glucose monitoring per week for 4 weeks then monthly for 2 months to verify glucometers are sanitized per policy. DON or designee will observe and audit 3 resident dressing changes per week for 4 weeks then monthly for 2 months to monitor infection control practices during procedure. DON and ED will review water management plan developed by contracting service when available. DON and QAPI committee will review infection control surveillance monthly. DON will review infection control tracking weekly for completion of surveillance tools and tracking of infections is ongoing throughout the month. Audits will be reviewed monthly at QAPI for 3 months. | |

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| F 441 | Continued From page 181<br>contained the same information. There was no additional information or other reports or analysis regarding infections in September 2017.<br><br>August 2017:<br>A Monthly Line Listing Report/Monthly Healthcare Associated Infection Incident Rate worksheet was filled with twenty-one (21) infection line listings. No monthly infection rate was calculated for August 2017. Under the August tab were sixteen (16) "Infection Surveillance Worksheets" which corresponded to line items on the report. In addition, there was a final urine culture report among the collected worksheets for August 2017. There was no additional information or other reports or analyses regarding infections in September 2017.<br><br>There were no surveillance worksheets or monthly line listings under tabs from January through May 2017. There were individual infection worksheets for June and July, but there was no documented line listing to track infection along with no analysis of infections completed during these months.<br><br>During interview on 10/3/17 at 1:56 p.m., (ADON)-C stated she was now responsible for the infection control program (ICP) and was still working on the September infection percentages and infection rate. ADON-C stated since last winter there were a number of changes at the director of nursing position, and each time the director left, the responsibility for the ICP was passed from one to another, and did not get done. ADON-C stated the ICP was formally given to me in August of 2107, "it was just handed to me" and stated she still had questions and needed further education regarding how to run | F 441 | DON and ED responsible for compliance. | |

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the ICP. ADON-C acknowledged current gaps in the monthly data, and lack of the current ICP, but stated going forward, there would be tracking and analysis, and review of the findings would be addressed during the monthly QAPI.

A facility policy, "Infection Prevention and Control Program, revised January 2017, indicated the goal of the program "is to identify and reduce risks of acquiring and transmitting infections among residents, employees, contract service workers, volunteers, students and visitors. The policy indicated "A coordinated process is established to reduce the risks of endemic and epidemic Healthcare Associated Infections in residents and HCWs. (health care workers). The policy indicated the process included prevention and surveillance control, and included tasks to document all resident infections; record infections on monthly line listing report; and present monthly line listing report to the Quality Assurance Performance Improvement (QAPI) committee.

WATER MANAGEMENT POLICY:

When interviewed on 10/3/17 at 2:298 p.m., the assitant director of nursing (ADON)-C istated she was not aware of any program begun in regard to a water management for the prevention of Legionnaire's disease. ADON-C stated she was aware of and had briefly looked at the CDC tool kit.

When interviewed on 10/4/17 at 1:29 p.m., the director or maintenance, (M)-A stated one of the regional directors of the facility had contacted him to set up a meeting to talk about the water

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management plan. The M-A mentioned a local company would coming to help the facility begin assessment of the water system as part of the water management plan. The M-A stated he was aware of the need to have a water management plan in place because, of "this Legionella" but stated we do not have policy in place right now. The M-A stated he had the (CDC) "toolkit" on his computer, but nothing down on paper.

When interviewed on 10/5/17 at 2:26 p.m. the assistant executive director, AED-A stated currently she had a date scheduled for a local company to begin testing in regard to the water management plan. The AED-A stated when had the CDC toolkit, and the facilty would be conducting a facility-wide assessment. The AED-A stated so far, that was what had been done in regards to creating a water management policy to address the Legionnaire's concern.

The facility provided no water management policy or procedure to address the potential of Legionnaire's disease in the facility.
LACK OF GLUCOMETER CLEANING:

An Assure Platinum Blood Glucose Monitoring System Quality Assurance / Quality Control Reference Manual dated 12/14, identified a frequently asked questions (FAQ) section under its cleaning procedures which dictated, "Blood glucose meters are at high risk of becoming contaminated with blood borne pathogens such as Hepatitis B Virus [HBV], Hepatitis C Virus [HCV], and Human Immunodeficiency Virus [HIV]. Transmission of these viruses from resident to resident has been documented due to contaminated blood glucose devices. According to the Centers for Disease Control and

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| F 441 | Continued From page 184<br>Prevention, cleaning and disinfecting of meters between resident use can prevent the transmission of these viruses through indirect contact." Further, the manual directed staff to clean the meter after each use with an EPA (Environmental Protection Agency) registered disinfectant or a solution of 1:10 concentration of bleach.<br><br>During observation on 10/4/17, at 6:54 a.m. licensed practical nurse (LPN)-D removed a community used Assure Platinum glucometer from a mobile medication cart on the first floor. The device was wrapped in a dried white cloth and seated in a green colored, handled container with unused lancets, device strips and alcohol wipes. LPN-D removed the dried white cloth and brought the device to R31's room. LPN-D pierced R31's skin using gloved hands, and obtained a sample of blood using the glucometer. Afterwards, LPN-D brought the device out of R31's room, placed it back on the medication cart and began to prepare R31's insulin for administration. LPN-D did not clean the glucometer with any wipes or chemicals after using it. At 7:43 a.m. LPN-D picked up the unclean glucometer and stated she was, "going to do the other blood sugar," and began to walk away from the medication cart, and into R89's room, with the device in her hand before being stopped by the surveyor.<br><br>When interviewed immediately following, LPN-D stated staff clean the device at night and it was, "supposed to be cleaned in between people," using a wipe which killed bacteria and viruses. LPN-D then cleaned the device using a designated wipe and stated it was important to clean it for, "contamination," purposes. | F 441 | | |

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A provided, undated 1st Floor Gluc(ometer) (checks) listing identified eight different residents had current glucometer checks ordered on the first floor of the facility.

During interview on 10/4/17, at 12:34 p.m. assistant director of nursing (ADON)-A stated the glucometer(s) needed to be cleaned inbetween each resident, "for infection control issues," in case blood or bodily fluid had been transferred onto the device. Further, ADON-A stated nursing staff had just received education on this subject recently.

A facility Equipment - Cleaning/Disinfecting/Sterilizing policy dated 1/2017, identified the facility, "...will take action to prevent resident care equipment and supplies from becoming sources of infection," and all used equipment, "will be cleaned and disinfected as applicable before use with another resident." The policy listed three categories, including critical, semi-critical and noncritical, and listed examples underneath of each while directing these items, "will be cleaned, disinfected and sterilized according to manufacturer recommendation and CDC guidelines." The policy did not specifically identify their process for cleaning and disinfecting a community glucometer.

APPROPRIATE INFECTION CONTROL TECHNIQUE DURING DRESSING CHANGE:

R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17,

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indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue). Physician's dated 8/30/17, directed staff to, "Cleanse wound, pat dry, Flagyl (antibiotic medication) 250 mg (Milligrams) tab (tablet) crushed into wound, wet to moist [wound pack] using Dakins Solution (liquid wound cleanser) BID (two times daily).

During observation on 10/2/17 at 12:24 p.m., licensed practical nurse (LPN)-C completed a dressing change to R121's wound. Nursing assistant (NA)-A and NA-W helped to hold and maintain R121's position on the bed during the removal and placement of the wound dressing. Prior to the dressing change, LPN-C prepared the bed side table in R121's room and gathered needed supplies, among which included sterile, unopened 4" (inch) x (by) 4" gauze squares, and Dakins Solution (or DK solution, a type of solution made form diluted bleach, treated to reduce irritation, and is an antiseptic that kills most forms of bacteria and viruses). LPN-C removed and discarded the outer bandage and the packed gauze dressing presently in R121's wound, and then cleansed the wound and surrounding skin. After washing hands and donning new gloves, LPN-C grasped a new, unopened 4" x 4" gauze dressing package. LPN-C opened the package by ripping a 3/4" strip off across the top of the package, and with the gloved hand, removed the gauze, and placed the empty package wrapper on top of the bed side table. Next, LPN-C placed the gauze 4 x 4 she just removed on top of the empty package wrapper, then poured about 30 ml (milliliters) of DK solution on the gauze. The gauze was soaking on top of the gauze package wrapper, all on top of the bed side table. LPN-C then grasped the soaked gauze, and lightly

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| F 441 | Continued From page 187<br>squeezed out excess DK solution. Then, along with the crushed medication, LPN-C repacked R121's wound with the solution-saturated gauze. LPN-C placed a top bandage on R121's wound pack, and the dressing change was completed.<br><br>When interviewed on 10/2/17 at 1:06 p.m. LPN-C explained R121's dressing change. LPN-C stated she opened the gauze package, removed the gauze 4 x 4, placed it on top of the wrapper (on the outside of its package), then poured the DK solution into the gauze. LPN-C stated the gauze, soaked with the DK solution, along with the crushed Flagyl was ordered to be packed into R121's wound. LPN-C did not question the procedure stated she considered this be be a "clean" and not "sterile technique" for the changing of R121's wound dressing.<br><br>During observation on 10/3/17 at 11:06 a.m., registered nurse (RN)-B completed a dressing change for R121's wound. NA-B and NA-D helped hold and maintain R121's position on the bed during procedure. Prior to R121's treatment, RN-B washed his hands, cleaned the bedside table, then gathered supplies, medications and placed them on the table. Next, RN-B donned large gloves, which he struggled to put on. With gloved hands, RN-B removed the outer dressing, the packed, gauze dressing from R121's wound, and folded the wound packing into the gloves while he removed the gloves, then placed the bandages and gloves in the trash. Without first washing or cleansing his hands, RN-B donned another pair of gloves, grasped a new gauze 4 x 4 package, and ripped a strip across the top of the package to open it, and with the gloved hand, removed the gauze. With the gauze in his hand, RN-B began to wipe around the outside of R121's | F 441 | | |

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| F 441 | Continued From page 188<br>wound, folding the gauze in half and making a second wipe around the wound edges. RN-B again folded his gloves and disposed of the gauze and soiled gloves. RN-B donned another pair of gloves, without washing or sanitize his hands, opened another package of 4 x 4 gauze. RN-B then grasped hold of a liquid spray bottle and announced this was a "liquid wound cleanser" and began to spray R121's wound, both inside and out. Immediately the spray mixed with exudate from the wound, then drained and cascaded down out of the wound, as well from the surrounding skin dripping onto the towel and bed linen. With the gauze in hand, RN-B began to blot R121's wound, soaking up the dripping liquid and wound drainage. While cleansing the wound, the spray bottle came in contact with exudate that had cascaded down onto the towel and bedding on R121's bed; the bottle was visibly damp. RN-B removed his soilded gloves and disposed the soiled gauze by folding the gloves onto it, before final disposal into the trash. Before repacking R121's wound, RN-B removed and donned another pair of gloves, tore open an new gauze 4x4, and packed R121's wound. RN-B applied a top bandage to cover the packed wound, and completed the treatment.<br><br>When interviewed on 10/3/17 at 4:32 p.m. RN-B stated during the dressing change he tried to maintain clean technique, and thought he struggled mostly to open the gauze packages. RN-B stated he was not aware the outside of the spray cleanser bottle came in contact with the drainage from cleansing R121's wound. RN-B stated he thought the dressing change didn't go "too bad." RN-B did state he washed his hands, but only after the entire dressing change was completed. | F 441 | | |

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| F 441 | Continued From page 189<br><br>When interviewed on 10/4/17 at 9:01 a.m., the assistant director of nursing (ADON)-C stated when opening a dressing package, like gauze, she would expect the package to be opened so as to expose the inside of the package, then pour the solution on top of that. ADON-C stated the outside wrapper was considered contaminated, "its filthy" ADON-C also stated it was important for staff to follow appropriate hand washing technique during dressing changes, and added "more education" regarding infection control was needed for the nurses. ADON-C stated this issue was very concerning because we have other residents with significant wounds.<br><br>A facility policy, Handwashing, dated January 2017, indicated Handwashing is the most important procedure for preventing healthcare acquired infections. The policy directed when staff was to wash hands, and indicated immediately after removing gloves. The policy required staff to use hand hygiene to remove dirt, organic material and transient microorganisms. | F 441 | | |
| F 465 SS=E | 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON<br><br>(i) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account | F 465 | | 11/13/17 |

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| F 465 | Continued From page 190<br>non-smoking residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and document review, the facility failed to manage facility odors in an acceptable manner on the 4th floor, affecting 2 residents (R84 and R2) residing in that room. There was ceiling tile was missing in room 329, potentially affecting R113, electric outlets were not in safe working order, room tiles, and window were also not maintained in room 104, affecting R111. Wall mounted fans were not cleaned in room 106 affecting R66, and the 1st floor dining room's (DR) ceiling and wall mounted fans were not cleaned, affecting 13 resident whom ate their meal in the first floor DR.<br><br>Findings include:<br><br>During the environmental tour, held on 10/3/17 at 2:25 p.m., the following issues were reviewed with the facility staff - maintenance director (M)-A, maintenance technician (MT), corporate carpenter/engineer (CCE), contracted housekeeping director - Healthcare Service Group, Inc. (HSKP) and assistant executive director (AED-A).<br><br>There was a strong, pungent urine odor in a resident room, where R82 and R2 resided. The smell lingered into the hallway, and was especially notable at the door into their room. Upon entering the room, R84 was observed sitting in a wheel chair (WC) looking out the window. R84's bed had only a fitted sheet with a soaker pad (pad used to absorb urine for resident that were incontinent), as well as, a vinyl recliner that also had a soaker pad. When approached, R84 had a strong pungent odor of concentrated | F 465 | 1) R85 and R2 rooms were deep cleaned to remove any odors. Room 329 missing ceiling tile was replaced on 10/03/2017. Room 104 electric outlets and missing window weather stripping was replaced on 10/03/2017. Room 106 wall mounted fans and 1st floor dining room mounted fan and ceiling fan were cleaned on 10/03/2017. Room 104 cracked tile was replaced.<br>2) Resident rooms have been assessed for odor, missing ceiling tiles, proper place electrical boxes, missing window weather stripping, dirty fans in both residents' rooms and in dining rooms, and cracked tiles. Rooms identified with deficient practices have been corrected.<br>3) Staff education on reporting environmental concerns in resident care areas. Housekeeping education on the Procedures for Fan Cleaning. Maintenance has been educated on completing daily rounds.<br>4) Five fan cleaning audits to be completed weekly for 4 weeks then monthly times 2 months by housekeeping supervisor. Five resident room audits for odors and five room audits for physical plant concerns to be completed weekly for 4 weeks then monthly times 2 months by maintenance and housekeeping supervisor. Audit findings will be reviewed by Executive Director and trend will be reviewed monthly at QAPI for 3 months. ED will monitor for compliance | |

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| F 465 | Continued From page 191<br>urine emanating from his person. The floor of the room was sticky, causing surveyor and staff's footsteps to be heard.<br><br>HKSP stated that R84 will not wear any incontinent products, while he states they are for "women". The family has replaced R84's recliner 3 times in the last 2 years due to being saturated with urine. When asked about odor control, they try charcoal, cleaners and have this room and 5 other rooms on a "6 times a day - everyday cleaning schedule" but the odors still persists. When asked if they have tried a urea-neutralizing cleaners (used to breakdown urine salts and proteins), HSKP stated that they have not. AED-A then asked HSPK why this product has not been used, to which HSKP stated that type of product is not listed in their contract for use within this facility.<br><br>On 10/3/17 at 2:34 p.m., maintenance technician (MT) stated when issues are noted the floor staff, have been instructed to contact maintenance and housekeeping. If there is an issue(s) that needs immediate attention, MT indicated they can call on the walkie-talkies, or call on the phone. They can also leave written information at the nursing stations, which would be picked up when maintenance and housekeeping rounds through the building each day.<br><br>On 10/3/17 at 2:44 p.m., the bathroom in room 329 was reviewed. The bathroom had a suspended ceiling with 2 foot (ft) x 3 ft ceiling tiles. The area above the toilet was missing a section of ceiling tile, that was approximately 6 ft x 2 ft, with the middle support bar missing that would of been between the 2-3 ft sections. MT stated maintenance was unaware of the missing | F 465 | | |

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tiles and both housekeeping and/or floor staff should report this to the maintenance department.

At 2:57 p.m. in room 104-1 (first bed in room - R111), noted a 4-outlet electrical box just above the mopboard, that was pulled off the wall between the wall and residents bed, and was hanging at a 45 degree angle, with the wires intact. The outlet was being used to run R111's electric Hi-Lo bed. Neither M-A, MT or HSKP were aware of this issue. MT stated it appeared staff lowered the Hi-Lo bed onto the outlet box dislodging it from the wall. This would be repaired right away. The threshold between the bathroom and bedroom was cracked with tile missing measuring approximately 18 inches in length and 1 inch in width. A piece of title was missing in the room measuring approximately four inches by nine inches by four inches. The CCE, identified this would be repaired, and the area did not provide a transition from the room to the other. The bedroom window had missing weather stripping which allowed an opening to the environment approximately 1/2 inch wide by the entire length of the window. The CCE stated this would be corrected immediately.

In Room 106 at 3:11 p.m., the oscillating wall fan next to the bathroom, had a heavy build up of gray dust, that occluded the fan cage. There were strings of dust (approximately 2-3 inches) blowing out from the fan cage. The blades of the fan also had a heavy buildup of dust and black debris on the edges. HSKP stated the fans should be cleaned on monthly basis.

In reviewing of the 1st floor dining room, at 3:24 p.m., a white ceiling fan, appeared gray with a

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heavy accumulation of gray dust. The on/off fan switch was broken off, and the fan could only be cleaned by turning the ceiling lights off. M-A stated they would have to fix the ceiling fan controls so that the housekeeping staff could clean the fan and fan blades. A oscillating wall fan, also located in the 1st Floor dining room, had a heavy build up with mats of gray dust on the fan cage. HSKP stated the housekeeper would not of been able to clean the ceiling fan, because it could not be turned off unless the light was off. She stated housekeeping should have noticed the wall fan, and should be cleaning this on a monthly basis. Licensed practical nurse (LPN)-B whom was in the dining room at this time, stated approximately 13 residents ate in the dining room.

In review of the facility policy, entitled: Maintenance and Repair: To Prevent Spread of Infection (revised January 2017), pertained more to "Personnel Health" (personal protection was to be used) and Preventative maintenance rather than what should be reported to maintenance / housekeeping for repairs . On page 3 of the same policy, in a section entitled: Pluming Supply and Drainage Systems , the policy indicated that the facility was to have "scheduled regular preventive maintenance for 7 systems, which included "sink fixtures" and the "water supply system."

The policy did not address electrical or ceiling tile issues.

A second facility maintenance policy, entitled: Physical Environment (effective July 2015), indicated that the facility "provides a safe, clean, comfortable, and home like environment for each resident..." and " all essential mechanical,

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electrical, and resident care equipment is maintained in safe operating condition through the center 'Preventative Maintenance Program'." The policy further indicated that the maintenance and housekeeping manager would be performing weekly rounds to include "resident rooms (10), common areas, offices, gym and laundry." This policy indicated that the facility would correct concerns found and keep results of the weekly rounds, providing them to quality assurance every 4 weeks.

Request for the last 3 months of weekly rounds, findings and completion records were requested, however wer not received.

Two separate policies were provided by HSKP, from Healthcare Services Group, Inc, - Housekeeping In-Service, both dated 1/1/2000. The first, entitled: Complete Room Cleaning, indicted the purpose of the policy was: "[insures] that each resident room is discharge-cleaned on a monthly basis. This policy made no mention of any of the concerns mentioned above. The second policy, entitled: 5-Step Daily Patient Room Cleaning, also did not mention what staff should do when noting missing ceiling tiles, dirt fans, fruit flies or other environmental concerns, only basis room cleaning.

HSKP was asked for cleaning logs for the 6 rooms designated as "to be cleaned six times a day" and fan cleaning for the last 3 months. However, on 10/5/17 at 12:43 p.m., the AED-A stated that neither HSKP nor the facility had supporting documentation that these 6 rooms and the fans noted were being completed, as referred to during environmental tour by HSKP.

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| F 469 | Continued From page 195 | F 469 | | |
| F 469 SS=C | 483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure adequate pest control was maintained for flying insects throughout the facility, which was mainly identified throughout the 1st floor and dining room. This deficient practice had the potential to affect all 95 residents (R31, R162, R130, R35) residing in the facility.<br><br>Findings include:<br><br>R31 was interviewed on 10/01/2017, at 9:53 a.m. stated the facility has problems with sewer flies, the water fountain doesn't work and it is rusted, and the unused bathroom tubs "I think the sewer flies come from there. The flies are everywhere." R31 further indicated a lot residents are coughing and hacking. R31 then stated " Last Monday I told administrator to do some thing about the fly problem, but I don't think anything was done about it". At 12:29 p.m. R31 stated "there are often sewer flies in the condiment trays, and if you twirl them around, they fly out."<br><br>During interview on 10/2/17, at 1:02 p.m., R31 stated there were sewer flies in the first floor dining room. When we are eating they really come out, and the flies came out of the dry drains and go to the food. At 12:02 p.m. licensed practical nurse (LPN)-E stated she had seen flies, but did not know where they came from. | F 469 | Identified<br>1) Contracted pest control visited center on 10/4/17. Pest control provided center with recommendations for management of pest control. R35's lunch tray removed from resident room. Plumbing services contacted and maintenance scheduled for 1st floor dining room sink.<br><br>Like<br>2) Floor drains to be deep cleaned and flushed per pest control recommendations. Floor coverings to be examined for cracks and potential of moisture collection. Any identified areas to be deep cleaned. Resident rooms to be audited for stored food that is not in enclosed containers. Center to continue having contracted pest control services audit building monthly and as needed.<br><br>Education<br>3) Staff educated to remove room food trays in a timely manner following meal times. Staff educated to alert maintenance with pest concerns. Executive Director, Director of Nursing, Assistant Executive Directors and Maintenance Director to review Insects/Pests: Resident Safety Policy.<br><br>Monitoring | 11/13/17 |

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| F 469 | Continued From page 196<br>During interview 10/01/17, at 10:06 a.m. R162 stated he had been at the facility for five months and the "This place sucks"! In addition R162 stated there is sewer flies in his room and the elevators.<br><br>During interview 10/01/2017, at 10:10 a.m. R130 stated he had been at the facility about a year. The food is cold I don't eat breakfast because its the same thing every day. In addition R130 stated he eat's in his room because of the bugs and there is lots of flies in the dinning room.<br><br>During observation 10/02/2017, at 12:51 p.m. observed a small black fly over R35's lunch tray in her room. An additional observation was observed of a fly in R35's room flying over R35's completed lunch tray again at 12:59 p.m.<br><br>During an observation on 10/02/2017 at 1:25 p.m., multiple fly's were seen flying around the 1st floor dining room. At 1:42 p.m. four flies were noted on the garbage bag, and six flies on the kitchenette wall.<br><br>During observation of the 3rd floor conference room on 10/03/2017 at 8:08 a.m., multiple small fly's was noted flying around the room.<br><br>While performing record review at the 1st floor nursing station, on 10/3/17 from 8:41 a.m. - 11:28 a.m., several flies were observe flying around the nursing station and residents areas on the first floor.<br><br>During observation on 10/03/2017, at 8:43 a.m. and at 9:00 a.m. at the first floor nurses station small black fly was flying around the desk. | F 469 | 4) Facility rounds to address pest control and food storage concerns will be completed by Maintenance Director or designee weekly for 4 weeks then monthly times 2 months. Audits will be reviewed monthly at QAPI for 3 months. Director of Nursing and Executive Director will monitor for compliance. | |

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| F 469 | Continued From page 197<br>During environmental tour, on 10/3/17 at 2:25 p.m., maintenance director (M)-A stated that he was aware of the "flies" being in the 1st floor dining room which was continuing for the past two week. He stated they were "fruit flies." He had the housekeepers washing out all the garbage cans in this area, and making sure food is not left in the dining room, and thought the problem was resolved. When M-A tapped the sink on the kitchenette of the 1st floor dining room, small black flies emanated from the sink area. M-A stated he would call a pest control company that day.<br><br>On 10/4/17 at 7:51 a.m., on a environmental tour with M-A and the contracted company's (Adam's Pest Control, Inc.) pest control technician (PCT), reviewed the facility "bug lights" wall sconces and the "glueboards" (sticky traps) placed inside of each light were inspected. The following was noted:<br><br>> On the 4th floor, the glueboard within the bug light, was noted to have trapped the following: approximately 5 house flies, one ground hornet, multiple black-eyed fruit flies and numerous fungus gnats. This light was located in the 4th floor dining area.<br>> On the 3rd floor bug light was located in the old dining area, now utilized a a open general storage area. The light's glueboard also had a three house flies, a two moths, a Eurasian beetle, multiple black-eyed fruit flies and a numerous of fungus gnats.<br>> On the 2nd floor dining area collected house flies, black-eyed fruit flies and fungus gnats. The bug light, located inside the delivery entrance of the kitchen on the 2nd floor, collected several house flies, multiple black-eyed fruit flies and | F 469 | | |

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| F 469 | Continued From page 198<br>fungus gnats. During the tour of the kitchen, PCT reached under the kitchen ice machine, and pulled from the floor drain, dark gray moist matter, with food debris.<br>> On the 1st floor dining room bug light glueboard, was found to have a number quantity of black-eyed fruit flies and fungus gnats.<br><br>During an interview 10/04/2017 9:10 a.m., PCT stated that black-eyed fruit fly / dark-eyed fruit flies, are much larger than regular fruit flies and are caused by collection of food /organic waste in high moisture locations, which can be controlled by thorough cleaning of breeding sites such as drain traps and garbage collection areas. PCT stated, like all flies, during the warmer months of the year, staff need to routinely clean these areas. PCT states areas such as drains (especially floor drains) may need to be power-washed, which included removing the floor drain grates and cleaning the undersides as well. The PCT suggested to M-A that all drains be flushed with 3-5 gallons of water, to assure the drains are free flowing, to help control all forms of fruit flies. PCT further suggested to M-A that all floor coverings (including vinyl and ceramic tiles) be inspected for cracks and potential areas that are dark and collect moisture. These areas need to be deep cleanse and disinfected. PCT stated that the fungus gnats, once it freezes outside should dramatically decrease in numbers, but as for the other flies (house, fruit and black-eyed fruit flies), warm moist dark areas will allow them to continue breeding throughout the winter. PCT denied the presence of "sewer flies" while the areas where they would breed, appear to be sealed and intact (no open sewer lines not missing caulking around toilets). | F 469 | | |

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| F 469 | Continued From page 199<br>In review of the facility's policy, entitled: Pest / Insect Control (effective July 2015), the policy indicated: "The center strives to protect the residents, staff and visitors from insects and other pests by controlling infestations through contracts with outside pest control agencies." However, the policy did not indicated how they, as a facility, would attempt to control and prevent infestations on a routine basis (i.e.: containment of refuge, routinely monitoring and cleaning breeding areas, thoroughly cleaning / removal of organic matter - as suggested by the PCT). | F 469 | | |
| F 490<br>SS=F | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to have adequate resources and guidance from the corporate ownership and administration to correct and maintain compliance with identified quality concerns related to resident care and insufficient staffing. This had potential to affect all 94 resident in the facility.<br><br>Findings include:<br><br>A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint investigations which had been filed with the State | F 490 | Residents are receiving care and services to attain and/or maintain resident's highest level of function and optimal well-being and are being treated with respect and dignity by qualified staff and in accordance of the facility's policies and procedures and standards of practice. Refer to plan of correction for citations related to but not limited to resident care and staffing.<br>Residents that reside in the facility are receiving care and services by qualified, trained staff in accordance with the facility's policies and procedures and standards of practice. Staffing was | 11/13/17 |

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| F 490 | Continued From page 200<br>agency (SA). The survey resulted in several deficiencies being cited, including examples at F164 (a lack of personal privacy being provided by staff during cares), F282 (not implementing the written plan of care), F312 (not providing activities of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility listed a plan of correction for each of these identified concerns, all of which had a completion date identified of 8/16/17.<br><br>During the current recertification survey, the following examples of continued quality of care concern(s) related to resident care and inadequate staffing are still occurring as follows:<br><br>The facility failed to ensure they had followed up on concerns presented at resident council meetings to the residents. During interview on 10/1/17, at 10:14 a.m. the resident council representative, R31 stated, "We are not getting anywhere with anything." R31 stated there have been concerns regarding closure of the resident store, understaffing, slow response to call lights, variance of time of medication administration in the morning from 7:30 a.m. and 11:30 a.m., and there was an extended period of time before residents who were incontinent received care by the facility staff.<br><br>A review of the resident council meeting minutes from 3/2/17 to 9/7/17 identified multiple concerns including staffing shortage that was related to long call light waits, not providing activities of daily living including dressing, incontinence, personal cares, and grooming. There was not enough nursing staff to administer medications, and resident complaints of the administration | F 490 | reviewed by Executive Director of Clinical Services and Director of Clinical Services to be appropriate.<br>Resident Centered Staffing Committee (RCSC) created to implement and monitor center's ongoing acuity level. Acuity staffing assessments will be conducted by the resident centered staffing committee at a minimum of monthly on the long term care units and weekly on the TCU to determine staffing ratios and staff deployment related to level of care. ED, DON, and Staffing coordinator have been educated on the acuity based staffing methodology by the Executive Director of Clinical Services. On a daily basis the ED, DON and staffing coordinator will review staffing and make adjustments as needed for acuity of the residents with input from the floor staff working the assigned units. The Client Support Center's clinical and operations staff will provide clinical and administrative oversight of the facility on weekly visits to monitor plan of correction, facility policies and procedures and standards of practice. Facility staff will continue with audits and reviews of the plans of correction as stated under individual F-tags. Reviews will be incorporated into the facility QAPI program and will be reviewed by the Client Support Center's DO and DCS upon visits to the facility.<br>All findings of reviews, audits and visits will be reviewed by the QAPI committee monthly x 3 months for opportunities of continued quality improvement.<br>The Director of Operations will monitor compliance. | |

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| F 490 | Continued From page 201 | F 490 | | |

removing the resident store from the facility. The 8/3/17, resident council minutes reflected the residents inquired whether legal services were available for a law suite against the facility and management staff so they would have adequate nurses/aides available to meet their need. They wanted management staff cut instead of the front line staff (nurses, and nursing assistants).

During interview on 10/5/17, at 10:48 a.m. the director of social services (DSS) stated he had been acting as the liaison of the resident council since July of 2017. There had been multiple resident concerns identified related to nursing and staffing concerns. These concerns were routed to the executive director (ED) to review for follow through. The DSS stated staffing was frequently addressed but there has been no resolution for the staffing concerns which are still a concern voiced by the residents. There was no indication the facility management had communicated with the residents about these concerns, nor was a resolution identified.

During interview on 10/5/17, at 2:35 p.m. the ED stated she was appointed approximately one month ago, and was aware of residents concerns regarding staffing and provision of cares and were working on these concerns.

R82's annual Minimum Data Set (MDS) dated 6/27/17, indicated R82 was cognitively intact. During interview on 10/2/17, at 1:30 p.m. R82 stated the facility was always short staffed, however, management said there was a low census, so they couldn't schedule more staff.

Nursing assistant (NA)-G stated on 10/4/17, at 9:12 a.m. the facility was short staffed adding the

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| F 490 | Continued From page 202<br>staffing on the 4th floor had been decreased in the past months, going from five scheduled NA staff to only four. NA-G stated call lights were not being answered timely still, at times, being left on for over an hour before staff are able to respond. Further, NA-G stated management was aware of these concerns with continued short staffing, however, nothing is done to improve the situation as staff are told by management they can not provide additional staff due to a low(er) census.<br><br>R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact, had an indwelling catheter and required extensive assistance to toilet. During interview on 10/1/17, at 3:55 p.m. R48 stated she needed to empty her own catheter and make her own bed because it took staff one to two hours to answer her call light. Further, R48 stated she had to fight with the facility to allow her nitroglycerin (medication used to treat chest pain) to be left at the bed side, because it took so long for staff to come and administer them medication when she was having chest pain.<br><br>R24's quarterly MDS dated 9/1/17, indicated R24 was cognitively intact and required extensive to total dependence of staff for ADL's. When interviewed on 10/2/17, at 1:28 p.m. R24 stated there were not enough nursing assistants and had to wait a half hour or more to have call lights answered. The call light would be answered and then shut off, staff say they would be back and don't come back for two hours. This has happened while being on the bed pan and it "made me very angry," and has been incontinent waiting for staff assistance. They don't have enough staff, and the staff they have are leaving because of the heavy workload. | F 490 | | |

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Health unit coordinator (HUC)-A stated on 10/3/17, at 11:02 a.m. the staffing on 4th floor was "horrible." Sometimes the resident needs were not being met as there were a lot of residents that needed two people to assist them. HUC-A stated there used to be five nursing assistant on 4th floor, but now management was only scheduling four nursing assistants. R6 frequently called the facility, when staff did not answer the call light. R55 was soiled with urine three to four times a week along with R2. She got R2 to his room and changed his urine soiled clothing, because the nursing staff didn't have the time to assist him.

RN-G stated on 10/3/17, at 2:53 p.m. there are two nursing assistants scheduled to work each wing of the 4th floor, for a total of four nursing assistants. RN-G stated there are at least 11 residents out of 26 on her wing that require two people for transfers and care and the other wing had a lot higher acuity level. We had a meeting with management one to two weeks ago and we brought up staffing concerns and were told it was not in the budget to add more nursing assistants. The management is not taking into account the level of care these residents need. Some residents are leaving and finding new places to live because their needs were not being met do to the lack of staff.

Assistant Director of Nursing (ADON)-A stated on 10/3/17, at 3:15 p.m. there are not enough aids scheduled in the facility to begin with. When NA's call in, the ADON's need to fill in on work on the floor providing personal cares, and passing medications. We get behind on the assessments and care plans. ADON-A stated there are a lot of

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| F 490 | Continued From page 204 | F 490 | | |

complaints from residents regarding not enough staff, but we do the best we can. The facility schedules by the number of resident not regarding their care needs. There has been increase in falls and incontinence directly related to the staffing levels.

The facility's Medical director (MD)-A stated on 10/5/17, at 2:33 p.m. he came to the facility on a regular basis for scheduled meetings. MD-A stated he was aware the facility had some concerns related to staffing and rapid personnel turn-over which had, "cut across all," levels of the facility and he was aware the facility had been cited in the past for staffing concerns. However, MD-A was not fully aware of all the identified care concerns (i.e. grooming not being completed, lack of timely repositioning to prevent skin breakdown, and bathing not being done) which had also been identified. MD-A stated he and facility administration had reviewed the cited SA findings at a meeting recently, however, some of the plans to address them must had been, "put on the back burner," or, "were never looked at again." MD-A stated one of the several issues the facility faced with the administration was they were always, "coming and going," and being replaced with new persons, adding the current ownership group seemingly did not fully understand the needs of the resident population or staff. Their focus was the, "economic bottom line," and they did not seem open to discussion or changes for, "continuing the promotion of quality care." MD-A stated the support for resident care needs from corporate administrative staff, "just aren't there," and again reiterated their oversight was focused on, "budget and economic issues." Further, MD-A stated he could recommend, "a number of things," to help improve patient care,

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| F 490 | Continued From page 205<br>however, if the money is not provided to the facility it, "just doesn't happen," and, "you can't get it done."<br><br>On 10/5/17, at 4:18 p.m. the executive director (ED), assistant executive director (AED)-A, assistant executive director (AED)-B, interim director of nursing (DON) and the director of quality (DOQ) were interviewed regarding the identified concerns during survey. DOQ stated she was aware resident care concerns remained in the facility adding, "we need exceptional care and that's not what we have." ED stated they need to get the nursing management team more involved. DOQ stated she felt staffing in the facility was better than it had been when the SA had originally cited during a complaint investigation, however, they wre still not getting many applicants for positions. Further, ED stated the administration had identified care related concerns remained in the facility since the SA survey in July 2017, however, there was no formal process in place to correct deficient practices identified by the team on the current survey process.<br><br>During interview on 10/5/17, at 5:15 p.m. the director of quality (DOQ) reported she and the facility management knew that Center Medicare/Medicaid Services (CMS) had sanctioned the facility. They were under the denial of payment remedy for new admission, effective 9/15/17, because the facilty has not been in compliance. She was directed by their facility management to keep taking new Medicare (MC) and Medicaid (MA) admissions, even though the facility will not receive any reimbursed for MC or MA residents. | F 490 | | |

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| F 490 | Continued From page 206<br>On 10/5/17, an interview was attempted with the deputy director of nursing (DDON). However, she had left the campus and was no longer available for interview. A return phone call was received on 10/10/17, at 12:02 p.m. from DDON. DDON stated she was aware the SA had been here in July 2017, and cited several concerns related to resident care areas and insufficient staffing. DDON stated the corporate nurse had helped develop the plan of correction at the time, however, "that is pretty much all the involvement from our corporate," they had received aside from some audits being completed by a corporate educator. DDON stated the ownership corporation had, "really no involvement," in helping the staff correct the identified concerns adding all of the unit managers in the facility had identified a need for additional staff, however, they are merely told, "we don't have the budget for it," by the corporate ownership. DDON stated these concerns had been voiced to the facility administrators, corporate nurse and the regional director of operations. The DDON went on and stated staff were not always even able to get the supplies they needed to care for the residents, as again, they are told, "we don't have the budget," adding quite often nursing management would indicate they were unable to care for newly referred patients, however, corporate would not listen and, "they [the new patient] would show up anyway."<br><br>A facility policy on administration management and responsibilities was requested, but was not provided. | F 490 | | |
| F 497 SS=E | 483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE | F 497 | | 11/13/17 |

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| F 497 | Continued From page 207<br>(d)(7) Regular In-Service Education<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure annual performance reviews were completed timely for 5 of 5 nursing assistants (NA-C, NA-F, NA-G, NA-H, NA-I) whose personnel records were reviewed.<br><br>Findings include:<br><br>An untitled, undated listing of employees was provided for review during the survey. The listing identified the following nursing assistant (NA) staff with their respective hire date(s):<br><br>- NA-C was hired in August 2016,<br>- NA-F was hired in July 2015,<br>- NA-G was hired in July 2015,<br>- NA-H was hired in February 2016 and,<br>- NA-I was hired in July 2015.<br><br>All of the above employee files were reviewed and lacked any evidence a performance evaluation had been completed since date of hire.<br><br>When interviewed on 10/5/17, at 1:00 p.m. the director of workforce management (DWM) stated none of the five NA staff reviewed had a performance evaluation completed since they were hired. DWM stated the facility was going to change the system for how performance | F 497 | Identified<br>1) NA-C, NA-F, NA-G, NA-H, NA-I have had their nursing assistant evaluations completed.<br><br>Like<br>2) NARs requiring annual performance evaluations will be completed. All evaluations moving forward to be completed in month of anniversary date.<br><br>Education<br>3) Human Resource Manager has been educated on importance of timely nursing assistant evaluations and tracking system has been created to ensure compliance and monitoring. Nurse managers educated on timely completion of annual nursing assistant evaluations.<br><br>Monitoring<br>4) HR will audit employee files monthly for anniversary dates and completion of performance evals and forward findings to ED. ED to present findings at QAPI committee monthly x 3 months.<br><br>Executive Director of monitor compliance. | |

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| F 497 | Continued From page 208<br>evaluations were completed, however, were only completing them going forward as the employee's yearly anniversary came. Further, DWM stated none of the reviewed NA staff had any current disciplinary actions on record.<br><br>A facility Employee Performance Appraisals policy dated 7/2015, identified evaluations should be completed, "at least annually." | F 497 | | |
| F 501 SS=F | 483.70(h)(1)(2) RESPONSIBILITIES OF MEDICAL DIRECTOR<br><br>(h) Medical director.<br><br>(1) The facility must designate a physician to serve as medical director.<br><br>(2) The medical director is responsible for-<br><br>(i) Implementation of resident care policies; and<br><br>(ii) The coordination of medical care in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure on-going collaboration with the medical director to ensure identified quality concerns related to activities of daily living (ADLs) and insufficient staffing were adequately addressed and resolved. This had potential to affect all 94 residents in the facility.<br><br>Findings include:<br><br>A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint | F 501 | 1) Medical Director was updated on 10/5/17 by ED and DON to promote ongoing collaboration and communication to include but not limited to quality care concerns related to activities of daily living and insufficient staffing. Weekly communication and status call has been scheduled with medical director, ED, and DON.<br>2) Medical Director updated on 10/20/17 with ED, DON, and AEDs about deficiencies received in the 2567. Golden Valley team communicated plan of correction for deficiencies with Medical | 11/13/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245186 | A. BUILDING ______<br>B. WING ______ | 10/05/2017 |

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| GOLDEN VALLEY REHABILITATION AND CARE CENTER | 7505 COUNTRY CLUB DRIVE<br>GOLDEN VALLEY, MN 55427 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 501 | Continued From page 209<br>investigations which had been filed with the State agency (SA). The survey resulted in several deficiencies being cited, including examples at F282 (not implementing the written plan of care), F312 (not providing activities of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility listed a plan of correction for each of these identified concerns, all of which had a completion date identified of 8/16/17.<br><br>During the current recertification survey, the following examples of continued concern(s) were identified:<br><br>The facility did not provide cares as identified on the care plan for 2 resident who required staff assistance for repositioning; 1 resident whom required range of motion. Pressure ulcer monitoring not completed for 1 resident with a stage 3 pressure ulcer, and activities of daily living (ADL's) were not provided for 3 residents who were dependent upon staff for ADL's. See F282 for additional information.<br><br>The facility did not provide assistance for nail care, bathing and personal hygiene which resulted in residents having dirty nails, greasy unkept hair, and strong pungent urine and body odor for 3 residents who were dependent upon staff for activities of daily. See F312 for additional information.<br><br>The facility did not provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 residents whom were dependent upon staff for ADL's, 2 residents who had pressure ulcers, 1 residents with range of motion needs, 2 residents who were not fed by authorized staff due to | F 501 | Director.<br>3) ED, DON, and AEDs educated and reviewed policy of Medical Director coverage and Medical Director agreement. Medical Director provided with a copy of agreement with center.<br>4) To ensure the medical director is involved in any plan of corrections, polices changes, compliance of polices the facility will communicate with the Medical Director through the quality assurance meeting, when the medical director rounds to see patients, or a phone conference when appropriate. Executive Director and Director of Nursing will complete a medical director communication log weekly ongoing. Director of Operations will review QAPI minutes monthly for medical director collaboration and medical director communication log for three months.<br>ED will monitor for compliance. | |

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| F 501 | Continued From page 210 | F 501 | | |

limited staffing need. In additional there were 16 residents and 14 staff members whom voiced concerns about the lack of sufficient nursing staff to provide care and services to residents in the facility. Refer to F353 for additional information

When interviewed on 10/5/17, at 2:33 p.m. the medical director (MD)-A stated he came to the facility on a regular basis for scheduled meetings. MD-A stated he was aware the facility had some concerns related to staffing and rapid personnel turn-over which had, "cut across all," levels of the facility. MD-A stated he was aware the facility had been cited in the past for staffing concerns, however, was not fully aware of all the identified care concerns (i.e. grooming not being completed, lack of timely repositioning to prevent skin breakdown, and bathing not being done) which had also been found. MD-A stated he and facility administration had reviewed the cited SA findings at a meeting recently, however, some of the plans to address them must had been, "put on the back burner," or, "we're never looked at again." MD-A stated the continued concerns of cares not being completed for residents, "certainly would be issues," which he should be included on to help develop a plan with, "what needs to be done," to correct them. Further, MD-A stated he was unaware the facility had an immediate jeopardy (IJ) determination on their current survey from two days prior, on 10/4/17, and he would call the facility to discuss this immediately.

On 10/5/17, at 2:56 p.m. the current executive director (ED), assistant executive director (AED)-A, and registered nurse director of quality (DOQ) were interviewed. DOQ stated MD-A was a, "huge support," to the facility and available

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| F 501 | Continued From page 211<br>readily when questions or needs arose from staff. DOQ stated MD-A had been made aware of the deficiencies cited during the last complaint survey, however, added she was, "unaware," of his involvement with developing any action plans to address them. Further, DOQ stated they should have involved MD-A more when addressing the identified concerns.<br><br>A facility Medical Director Agreement dated 6/10/16, identified MD-A to be the current, acting medical director for the facility. The agreement listed objectives including to have the medical director, "... ensure that residents at the Facility receive quality medical care," and, " ... assisting in the monitoring of resident care polices and coordinating medical care in the Facility." Further, the agreement listed several responsibilities of the medical director including, "Provide medical direction and overall coordination of medical care in the Facility," and, "Be responsible for evaluating and taking appropriate steps to correct situations of possible inadequate medical care that is identified by or reported to the Medical Director." | F 501 | | |
| F 520 SS=F | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee; | F 520 | | 11/13/17 |

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| F 520 | Continued From page 212<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the quality and assurance team developed and revised a quality improvement program to correct staffing and identified resident care issues, previously identified. This practice had the potential to affect all 94 residents residing in the facility. | F 520 | Identified<br>1) The center has developed a quality assurance and improvement plan. Center will maintain a QAPI committee which will include monitoring any deficient practices for quality improvements to include but not limited to F164, F282, F312, F353, and F309. The medical director will be | |

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| F 520 | Continued From page 213<br>Findings include:<br><br>A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint investigations which had been filed with the State agency (SA). The survey resulted in several deficiencies being cited, including examples at F164 (a lack of personal privacy being provided by staff during cares), F282 (not implementing the written plan of care), F312 (not providing activities of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility completed a plan of correction listed a correction date for each of these identified concerns, all of which had a completion date identified of 8/16/17.<br><br>During the current recertification survey, the following examples of continued concern(s) were identified:<br><br>- See F164; as the facility failed to provide personal privacy for 1 of 6 residents (R121) during observations of personal cares<br><br>- See F282; as the facility failed to ensure care plan interventions was implemented as directed for 2 of 3 residents (R134, R121) who required staff assistance for repositioning; 1 of 1 resident (R121) whom required range of motion. In addition, skin monitoring not completed for 1 of 2 resident (R6) with a current pressure ulcer and activities of daily living (ADL's) were not completed for 3 of 5 residents (R183, R55, R2) dependent upon staff for ADL's.<br><br>- See F312; as the facility failed to ensure | F 520 | actively involved in the QAPI committee and plans.<br><br>Like<br>2) Action plan will be developed to review all the plan of correction deficiencies at quality assurance and performance improvement meeting to be reviewed on a monthly basis. QAPI meetings will be held to include the Executive Director, Director of Nursing, Medical Director and at a minimum 3 other members of facility staff.<br><br>Education<br>3) Each leadership team members have been educated on accountability for actively participating in our quality assurance and performance improvement process that include efficient mechanisms for monitoring, revising, analyzing, documenting and improving processes. Leadership team members are educated on responsibility for bringing all plan of correction audits and monitoring to present compliance results to the committee. QAPI policy and procedures have been reviewed and leadership team member s has been educated.<br><br>Monitoring<br>4) Performance improvement activities will be completed monthly for 3 months or as indicated by the individual plans of correction and will be reviewed by the QAPI committed for 3 months or until deemed necessary by the committee. Director of Operations/Director of clinical services will audit QAPI minutes to ensure | |

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| F 520 | Continued From page 214<br>residents were assisted with personal hygiene for 3 of 5 residents (R55, R2, R183) reviewed for activities of daily living (ADL) and who were dependent on staff for care.<br><br>- See F353; The facility did not provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 residents (R55, R2, R183) whom were dependent upon staff for ADL's, 2 residents (R134, R121) reviewed for pressure ulcers, 1 residents (R121) with range of motion needs, 2 residents (R19, R97) who were not fed by authorized staff due to limited staffing need. In additional there were 16 residents (R48, R28, R196, R180, R162, R47, R6, R31, R24, R82, R130, R192, R43, R31, R66, R183) and 14 staff members (RN-C, HUC-A, NA-C, RN-E, RN-G, ADON-A, HN-A, LPN-E, LPN-I, NA-E, NA-G, NA-H, ADON-C, AS) whom voiced concerns about the lack of sufficient nursing staff to provide care and services to residents in the facility.<br><br>On 10/5/17, at 4:18 p.m. the executive director (ED), assistant executive director (AED)-A, assistant executive director (AED)-B, interim director of nursing (DON) and the director of quality (DOQ) were interviewed regarding the effectiveness of the quality assurance (QA) team to correct deficient practices. ED stated the QA team met monthly and consisted at minimum DON, physician, and at least three other staff members, including the ED. ED stated the QA meeting discussed standard quality measures such as staffing (retention and turnover), infection control, financial, re-hospitalization, safety and census information. ED stated if the QA team identifies an issue it is made a focus for the next "few" meetings. ED, AED-A and ADA-B stated the | F 520 | the action plan is updated monthly for three months.<br><br>ED and Director of Operations will monitor compliance. | |

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| F 520 | Continued From page 215 facility started a caring partners program where each manager meets with a group of resident to identify concerns the resident may have. Then the manager brings the concerns to the nursing team to address. They have just started the process and completed the first month of tracking information, but did not have a formal plan to go forward with the program or how they are ensuring concerns brought forward are followed up as required. The DOQ stated a big factor the QA team has identified is a culture among the staff telling people it isn't their job, or they will get to it when they have time. The team has spent a lot of time re-educating staff and following up with discipline. " We need exceptional care and that's not what we have." There has been some improvement since the change of administrators, as this team listens to the staff, which is an important part of staff retention. ED stated they recognize they are not nurses and need to get the nursing management team involved. The DOQ stated from a staffing perspective there has been an improvement in staffing, and it is better that June and July of 2017. AED-B stated the facility was better able to get coverage for staff call-ins. DOQ stated the facility was having problems with applicants; however, they have more staff now then in June and July 2017. AED-B talked about staff retention and the facility adding things to recognize staff such as: celebrating birthdays, doing a snack cart, thank you cares, supporting staff on medical leave. ED stated QA reviewed five random audits at QA meetings. ED stated the team had identified care related concerns and although the team has started implementing caring partners it was just starting and there was no formal process in place to correct deficient practices identified by the team or the survey process. The team also recognized ongoing | F 520 | | |

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| F 520 | Continued From page 216<br>concerns with deficient practices and could not articulate what changes they made to the plan to correct the previously cited deficiencies to ensure the facility meets the minimal requirements.<br><br>The facility policy Quality Assurance and Performance Improvement (QAPI) Process revised 1/17, indicated "The center pursues the highest quality of care and services for their customers through a data-driven, proactive approach to improving the quality of life, care, and services. The activities of QAPI involve members at all levels of our organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions. Each Center leadership team with Client Support Center is accountable for actively participating in the formalized and documented Quality Assurance and Performance Improvement (QAPI) Process that includes efficient mechanisms for monitoring, revising, analyzing, documenting and improving processes in the following areas at a minimum: Customers (Satisfaction), Employees (Turnover, Registry Use, Satisfaction), Quality of Life/Care (QMs, Readmission to Hospital, Restorative, 5Star, Abaqis),Financial (NOI, DSO, Labor), Growth (ADC, MC, PMC)." | F 520 | | |

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| K 000 | INITIAL COMMENTS | K 000 | | |

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 13, 2017. At the time of this survey, Golden Valley Rehab & Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 10/26/2017 |

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.

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| K 000 | Continued From page 1<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Golden Valley Rehab and Care Center is a 3-story building with a partial basement that was constructed in 1972 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification.<br><br>The facility has a capacity of 164 beds and had a census of 85 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 223<br>SS=C | NFPA 101 Doors with Self-Closing Devices<br><br>Doors with Self-Closing Devices | K 223 | | 11/13/17 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| K 223 | Continued From page 2<br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility did not maintain self-closing doors in exit passageways, stairway enclosures, horizontal exits, smoke barriers, or hazardous areas. 19.2.2.2.7, 19.2.2.2.8. This deficient practice could affect all 85 residents.<br><br>Findings include:<br><br>On a facility tour between the hours of 1000 and 1500 on October 13, 2017, observation revealed that the first floor North stairwell door did not have a fire rating tag.<br><br>This deficient practice was verified by a Assistant Executive Director at the time of discovery. | K 223 | Identified<br>The fire door identified that was missing its fire rating tag will be replaced.<br>Person Responsible/Monitoring<br>The Maintenance director or designee has completed an audit to ensure no other fire doors were missing the fire rating tag.<br>The maintenance director will responsible to ensure all fire doors have proper fire rating identification on the doors through regular audits to prevent reoccurrence. | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota | 2 000 | | |


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Electronically Signed 10/26/17

Minnesota Department of Health

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On 10/1 thru 10/5/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A | 2 000 | | |

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| 2 000 | Continued From page 2<br>PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 130 | MN Rule 4658.0050 Subp. 1 Licensee;General duties<br><br>Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to have adequate resources and guidance from the corporate ownership and administration to correct and maintain compliance with identified quality concerns related to resident care and insufficient staffing. This had potential to affect all 94 resident in the facility.<br><br>Findings include:<br><br>A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint investigations which had been filed with the State agency (SA). The survey resulted in several deficiencies being cited, including examples at F164 (a lack of personal privacy being provided by staff during cares), F282 (not implementing the written plan of care), F312 (not providing activities | 2 130 | Corrected | 11/13/17 |

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| 2 130 | Continued From page 3 | 2 130 | | |

of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility listed a plan of correction for each of these identified concerns, all of which had a completion date identified of 8/16/17.

During the current recertification survey, the following examples of continued quality of care concern(s) related to resident care and inadequate staffing are still occurring as follows:

The facility failed to ensure they had followed up on concerns presented at resident council meetings to the residents. During interview on 10/1/17, at 10:14 a.m. the resident council representative, R31 stated, "We are not getting anywhere with anything." R31 stated there have been concerns regarding closure of the resident store, understaffing, slow response to call lights, variance of time of medication administration in the morning from 7:30 a.m. and 11:30 a.m., and there was an extended period of time before residents who were incontinent received care by the facility staff.

A review of the resident council meeting minutes from 3/2/17 to 9/7/17 identified multiple concerns including staffing shortage that was related to long call light waits, not providing activities of daily living including dressing, incontinence, personal cares, and grooming. There was not enough nursing staff to administer medications, and resident complaints of the administration removing the resident store from the facility. The 8/3/17, resident council minutes reflected the residents inquired whether legal services were available for a law suite against the facility and management staff so they would have adequate nurses/aides available to meet their need. They

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wanted management staff cut instead of the front line staff (nurses, and nursing assistants).

During interview on 10/5/17, at 10:48 a.m. the director of social services (DSS) stated he had been acting as the liaison of the resident council since July of 2017. There had been multiple resident concerns identified related to nursing and staffing concerns. These concerns were routed to the executive director (ED) to review for follow through. The DSS stated staffing was frequently addressed but there has been no resolution for the staffing concerns which are still a concern voiced by the residents. There was no indication the facility management had communicated with the residents about these concerns, nor was a resolution identified.

During interview on 10/5/17, at 2:35 p.m. the ED stated she was appointed approximately one month ago, and was aware of residents concerns regarding staffing and provision of cares and were working on these concerns.

R82's annual Minimum Data Set (MDS) dated 6/27/17, indicated R82 was cognitively intact. During interview on 10/2/17, at 1:30 p.m. R82 stated the facility was always short staffed, however, management said there was a low census, so they couldn't schedule more staff.

Nursing assistant (NA)-G stated on 10/4/17, at 9:12 a.m. the facility was short staffed adding the staffing on the 4th floor had been decreased in the past months, going from five scheduled NA staff to only four. NA-G stated call lights were not being answered timely still, at times, being left on for over an hour before staff are able to respond. Further, NA-G stated management was aware of these concerns with continued short staffing,

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however, nothing is done to improve the situation as staff are told by management they can not provide additional staff due to a low(er) census.

R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact, had an indwelling catheter and required extensive assistance to toilet. During interview on 10/1/17, at 3:55 p.m. R48 stated she needed to empty her own catheter and make her own bed because it took staff one to two hours to answer her call light. Further, R48 stated she had to fight with the facility to allow her nitroglycerin (medication used to treat chest pain) to be left at the bed side, because it took so long for staff to come and administer them medication when she was having chest pain.

R24's quarterly MDS dated 9/1/17, indicated R24 was cognitively intact and required extensive to total dependence of staff for ADL's. When interviewed on 10/2/17, at 1:28 p.m. R24 stated there were not enough nursing assistants and had to wait a half hour or more to have call lights answered. The call light would be answered and then shut off, staff say they would be back and don't come back for two hours. This has happened while being on the bed pan and it "made me very angry," and has been incontinent waiting for staff assistance. They don't have enough staff, and the staff they have are leaving because of the heavy workload.

Health unit coordinator (HUC)-A stated on 10/3/17, at 11:02 a.m. the staffing on 4th floor was "horrible." Sometimes the resident needs were not being met as there were a lot of residents that needed two people to assist them. HUC-A stated there used to be five nursing assistant on 4th floor, but now management was

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only scheduling four nursing assistants. R6 frequently called the facility, when staff did not answer the call light. R55 was soiled with urine three to four times a week along with R2. She got R2 to his room and changed his urine soiled clothing, because the nursing staff didn't have the time to assist him.

RN-G stated on 10/3/17, at 2:53 p.m. there are two nursing assistants scheduled to work each wing of the 4th floor, for a total of four nursing assistants. RN-G stated there are at least 11 residents out of 26 on her wing that require two people for transfers and care and the other wing had a lot higher acuity level. We had a meeting with management one to two weeks ago and we brought up staffing concerns and were told it was not in the budget to add more nursing assistants. The management is not taking into account the level of care these residents need. Some residents are leaving and finding new places to live because their needs were not being met do to the lack of staff.

Assistant Director of Nursing (ADON)-A stated on 10/3/17, at 3:15 p.m. there are not enough aids scheduled in the facility to begin with. When NA's call in, the ADON's need to fill in on work on the floor providing personal cares, and passing medications. We get behind on the assessments and care plans. ADON-A stated there are a lot of complaints from residents regarding not enough staff, but we do the best we can. The facility schedules by the number of resident not regarding their care needs. There has been increase in falls and incontinence directly related to the staffing levels.

The facility's Medical director (MD)-A stated on 10/5/17, at 2:33 p.m. he came to the facility on a

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regular basis for scheduled meetings. MD-A stated he was aware the facility had some concerns related to staffing and rapid personnel turn-over which had, "cut across all," levels of the facility and he was aware the facility had been cited in the past for staffing concerns. However, MD-A was not fully aware of all the identified care concerns (i.e. grooming not being completed, lack of timely repositioning to prevent skin breakdown, and bathing not being done) which had also been identified. MD-A stated he and facility administration had reviewed the cited SA findings at a meeting recently, however, some of the plans to address them must had been, "put on the back burner," or, "were never looked at again." MD-A stated one of the several issues the facility faced with the administration was they were always, "coming and going," and being replaced with new persons, adding the current ownership group seemingly did not fully understand the needs of the resident population or staff. Their focus was the, "economic bottom line," and they did not seem open to discussion or changes for, "continuing the promotion of quality care." MD-A stated the support for resident care needs from corporate administrative staff, "just aren't there," and again reiterated their oversight was focused on, "budget and economic issues." Further, MD-A stated he could recommend, "a number of things," to help improve patient care, however, if the money is not provided to the facility it, "just doesn't happen," and, "you can't get it done."

On 10/5/17, at 4:18 p.m. the executive director (ED), assistant executive director (AED)-A, assistant executive director (AED)-B, interim director of nursing (DON) and the director of quality (DOQ) were interviewed regarding the identified concerns during survey. DOQ stated

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| 2 130 | Continued From page 8<br>she was aware resident care concerns remained in the facility adding, "we need exceptional care and that's not what we have." ED stated they need to get the nursing management team more involved. DOQ stated she felt staffing in the facility was better than it had been when the SA had originally cited during a complaint investigation, however, they wre still not getting many applicants for positions. Further, ED stated the administration had identified care related concerns remained in the facility since the SA survey in July 2017, however, there was no formal process in place to correct deficient practices identified by the team on the current survey process.<br><br>During interview on 10/5/17, at 5:15 p.m. the director of quality (DOQ) reported she and the facility management knew that Center Medicare/Medicaid Services (CMS) had sanctioned the facility. They were under the denial of payment remedy for new admission, effective 9/15/17, because the facilty has not been in compliance. She was directed by their facility management to keep taking new Medicare (MC) and Medicaid (MA) admissions, even though the facility will not receive any reimbursed for MC or MA residents.<br><br>On 10/5/17, an interview was attempted with the deputy director of nursing (DDON). However, she had left the campus and was no longer available for interview. A return phone call was received on 10/10/17, at 12:02 p.m. from DDON. DDON stated she was aware the SA had been here in July 2017, and cited several concerns related to resident care areas and insufficient staffing. DDON stated the corporate nurse had helped develop the plan of correction at the time, however, "that is pretty much all the involvement | 2 130 | | |

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from our corporate," they had received aside from some audits being completed by a corporate educator. DDON stated the ownership corporation had, "really no involvement," in helping the staff correct the identified concerns adding all of the unit managers in the facility had identified a need for additional staff, however, they are merely told, "we don't have the budget for it," by the corporate ownership. DDON stated these concerns had been voiced to the facility administrators, corporate nurse and the regional director of operations. The DDON went on and stated staff were not always even able to get the supplies they needed to care for the residents, as again, they are told, "we don't have the budget," adding quite often nursing management would indicate they were unable to care for newly referred patients, however, corporate would not listen and, "they [the new patient] would show up anyway."

A facility policy on administration management and responsibilities was requested, but was not provided.

SUGGESTED METHOD OF CORRECTION:
The corporate owner(s) and or designees could review industry standards for staffing and budgeting for facility fiscal needs, and implement appropriate changes for the quality, health and safety of their resident population. The corporate owners or designees could complete audits of resident cares, resident satisfaction surveys, staffing patterns and staff competency to ensure resident needs are consistently met.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

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| 2 255 | MN Rule 4658.0070 Quality Assessment and Assurance Committee<br><br>A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed as a quality and assurance team to develop and revise a quality improvement program to correct staffing and identified resident care issues, previously identified. This practice had the potential to affect all 94 residents residing in the facility.<br><br>Findings include:<br><br>A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint investigations which had been filed with the State agency (SA). The survey resulted in several deficiencies being cited, including examples at F164 (a lack of personal privacy being provided | 2 255 | Corrected | 11/13/17 |

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by staff during cares), F282 (not implementing the written plan of care), F312 (not providing activities of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility listed a plan of correction for each of these identified concerns, all of which had a completion date identified of 8/16/17.

During the current recertification survey, the following examples of continued concern(s) were identified:

- See F164; as the facility failed to provide personal privacy for 1 of 6 residents (R121) during observations of personal cares

- See F282; as the facility failed to ensure care plan interventions was implemented as directed for 2 of 3 residents (R134, R121) who required staff assistance for repositioning; 1 of 1 resident (R121) whom required range of motion. In addition, skin monitoring not completed for 1 of 2 resident (R6) with a current pressure ulcer and activities of daily living (ADL's) were not completed for 3 of 5 residents (R183, R55, R2) dependent upon staff for ADL's.

- See F312; as the facility failed to ensure residents were assisted with personal hygiene for 3 of 5 residents (R55, R2, R183) reviewed for activities of daily living (ADL) and who were dependent on staff for care.

- See F353; The facility did not provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 residents (R55, R2, R183) whom were dependent upon staff for ADL's, 2 residents (R134, R121) reviewed for pressure ulcers, 1 residents (R121) with range of motion needs, 2

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residents (R19, R97) who were not fed by authorized staff due to limited staffing need. In additional there were 16 residents (R48, R28, R196, R180, R162, R47, R6, R31, R24, R82, R130, R192, R43, R31, R66, R183) and 14 staff members (RN-C, HUC-A, NA-C, RN-E, RN-G, ADON-A, HN-A, LPN-E, LPN-I, NA-E, NA-G, NA-H, ADON-C, AS) whom voiced concerns about the lack of sufficient nursing staff to provide care and services to residents in the facility.

On 10/5/17, at 4:18 p.m. the executive director (ED), assistant executive director (AED)-A, assistant executive director (AED)-B, interim director of nursing (DON) and the director of quality (DOQ) were interviewed regarding the effectiveness of the quality assurance (QA) team to correct deficient practices. ED stated the QA team met monthly and consisted at minimum DON, physician, and at least three other staff members, including the ED. ED stated the QA meeting discussed standard quality measures such as staffing (retention and turnover), infection control, financial, re-hospitalization, safety and census information. ED stated if the QA team identifies an issue it is made a focus for the next "few" meetings. ED, AED-A and ADA-B stated the facility started a caring partners program where each manager meets with a group of resident to identify concerns the resident may have. Then the manager brings the concerns to the nursing team to address. The have just started the process and completed the first month of tracking the information, but did not have a formal plan to go forward wit the program or how they are ensuring concerns brought forward had the follow up the need required. The DOQ stated a big factor the QA team has identified is a culture among the staff telling people it isn't their job, or they will get to it when they have time. The team

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has spent a lot of time re-educating staff and following up with discipline. " We need exceptional care and that's not what we have." There has been some improvement since the change of administrators, as this team listens to the staff, which is an important part of staff retention. ED stated they recognize they are not nurse and need to get the nursing management team involved. The DOQ stated from a staffing perspective there has been an improvement in staffing, and it is better that June and July of 2017. AED-B stated the facility was better able to get coverage for staff call-ins. DOQ stated the facility was having problems with applicants; however, they have more staff now then in June and July 2017. AED-B talked about staff retention and the facility adding things to recognize staff such as: celebrating birthdays, doing a snack cart, thank you cares, supporting staff on medical leave. ED stated QA reviewed five random audits at QA meetings. ED stated the team had identified care related concerns and although the team has started implementing caring partners it was just starting and there was no formal process in place to correct deficient practices identified by the team or the survey process. The team also recognized ongoing concerns with deficient practices and could not articulate what changes they made to the plan to correct the previously cited deficiencies to ensure the facility meets the minimal requirements.

The facility policy Quality Assurance and Performance Improvement (QAPI) Process revised 1/17, indicated "The center pursues the highest quality of care and services for their customers through a data-driven, proactive approach to improving the quality of life, care, and services. The activities of QAPI involve members at all levels of our organization to:

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| 2 255 | Continued From page 14<br>identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions. Each Center leadership team with Client Support Center is accountable for actively participating in the formalized and documented Quality Assurance and Performance Improvement (QAPI) Process that includes efficient mechanisms for monitoring, revising, analyzing, documenting and improving processes in the following areas at a minimum: Customers (Satisfaction), Employees (Turnover, Registry Use, Satisfaction), Quality of Life/Care (QMs, Readmission to Hospital, Restorative, 5Star, Abaqis),Financial (NOI, DSO, Labor), Growth (ADC, MC, PMC)."<br><br>SUGGESTED METHOD OF CORRECTION: The corporate enity and/or designees could review past and current systematic issues idenfied by both the state agency and the facility, and create effective quality assurance plans, revising as needed to meet facility goals. The facility could monitor the systematic changes and plans made to ensure resident needs are consistently met.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 255 | | |
| 2 265 | MN Rule 4658.0085 Notification of Chg in Resident Health Status<br><br>A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's | 2 265 | | 11/13/17 |

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legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:

A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;

C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the resident's representative was notified timely of medication changes, updates on condition and treatment requiring injection of medication for 1 of 1 resident (R16) reviewed for notification of change.

Corrected

Findings include:

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R16's quarterly Minimum Data Set (MDS) completed on 7/13/17, identified moderate cognitive impairment and moderate depression.

R16's Admission Record dated 5/1/17, identified family member (FM)-A as Emergency Contact #1, Responsible Party, and POA-Financial, with a hand written, undated entry identifying "legal guardian."

During interview on 10/2/17, at 3:51 p.m. FM-A stated the facility had called when a recent fall occurred, but notification had not been made related to medication changes or new orders. FM-A added R16 has had medication changes and she had only became aware of it when reviewing the pharmacy statement. FM-A stated she visited routinely and interacted with staff with any concerns either during visit or via a phone call.

A review of physician's orders of 7/16/17, identified medication changes were made to discontinue Cogentin (a medication used to lessen the side effects of antipsychotic medications) and change to amantadine (a medication used to treat Parkinson's disease). A review of nursing progress notes did not identify order changes made, nor did it identify notification of FM-A of any changes.

A review of physician's orders noted R16 was on Seroquel 100 milligrams (mg) on 8/22/17, with orders for one tablet every four hours as needed for psychotic behaviors. A review of nursing progress notes did not reflect the new order or notification of FM-A of the new medication.

A review of the nursing progress note dated

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9/3/17, indicated R16 was given a dose of Seroquel which had been ordered on an as needed basis (PRN). Seroquel is an antipsychotic drug which was ordered for psychotic symptoms. FM-A was contacted to inform of R16's mood state and of medication administration. The documentation identified FM-A stated there had been medication changes based on psychiatric recommendations.

The next narrative note on R16's record was dated 9/15/17, and addressed physician visit for joint injection. The note did not reflect the awareness of FM-A regarding the interventions provided.

A review of the physician's orders from 9/15/17, identified a joint injection had been given and orders were received for a Lidoderm patch. No nursing progress notes were present to identify new orders or notification of the responsible party of the new medication therapy.

On 9/25/17, the progress notes identified a change of orders for Percocet (a narcotic pain medication) to increase dosage to twice daily. The record lacked documentation regarding notification of FM-A of change in treatment.

Upon review of recent medication changes, notification of family regarding new orders was not always documented. During interview on 10/5/17, at 9:52 a.m. the assistant director of nursing (ADON)-B stated this should have been completed when the orders were processed.

A policy was requested for transcription of physician orders and notification of responsible parties/family members of change in condition or medication orders but was not received.

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| | SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could develop policies for licensed personnel to contact residents / family / guardians of changes in any physician orders and/or changes in resident care or status. The DON or designee could educate licensed staff on those policies and conduct audits of physician orders and or changes in resident care or status to ensure the staff are following those policies.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | | | |
| 2 335 | MN Rule 4658.0130 Employees' Personnel Records<br><br>A current personnel record must be maintained for each employee and be stored in a confidential manner. The personnel records for at least the most recent three-year period must be maintained by the nursing home. The records must be available to representatives of the department and must contain:<br><br>A. the person's name, address, telephone number, gender, Minnesota license, certification, or registration number, if applicable, and similar identifying data;<br>B. a list of the individual's training, experience, and previous employment;<br>C. the date of employment, type of position currently held, hours of work, and attendance records; and<br>D. the date of resignation or discharge. | 2 335 | | 11/13/17 |

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| 2 335 | Continued From page 19<br>Employee health information, including the record of all accidents and those illnesses reportable under part 4605.7040, must be maintained and stored in a separate employee medical record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure annual performance reviews were completed timely for 5 of 5 nursing assistants (NA-C, NA-F, NA-G, NA-H, NA-I) whose personnel records were reviewed.<br><br>Findings include:<br><br>An untitled, undated listing of employees was provided for review during the survey. The listing identified the following nursing assistant (NA) staff with their respective hire date(s):<br><br>- NA-C was hired in August 2016,<br>- NA-F was hired in July 2015,<br>- NA-G was hired in July 2015,<br>- NA-H was hired in February 2016 and,<br>- NA-I was hired in July 2015.<br><br>All of the above employee files were reviewed and lacked any evidence a performance evaluation had been completed since date of hire.<br><br>When interviewed on 10/5/17, at 1:00 p.m. the director of workforce management (DWM) stated none of the five NA staff reviewed had a performance evaluation completed since they were hired. DWM stated the facility was going to change the system for how performance evaluations were completed, however, were only completing them going forward as the employee's yearly anniversary came. Further, DWM stated | 2 335 | Corrected | |

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| 2 335 | Continued From page 20<br>none of the reviewed NA staff had any current disciplinary actions on record.<br><br>A facility Employee Performance Appraisals policy dated 7/2015, identified evaluations should be completed, "at least annually."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policy for performance reviews, educate staff on those policies to ensure nursing staff, including nursing assistance, to staffs' performance has been reviewed. The DON or designee could conduct audits of employee files to ensure the employee performance reviews have been completed on a consistent basis.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 335 | | |
| 2 435 | MN Rule 4658.0210 Subp. 2 A.B. Room Assignments<br><br>Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following:<br>A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and<br>B. a procedure for documenting the complaint and its resolution.<br><br>This MN Requirement is not met as evidenced | 2 435 | | 11/13/17 |

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by:
Based on interview and document review, the facility failed to ensure notice of a new roommate was provided to 2 of 3 residents ( R130, R48) reviewed for facility admission, transfer and discharge practices.

Corrected

Findings include:

R130's quarterly Minimum Data Set (MDS) dated 08/15/17, identified R130 was cognitively intact with no behaviors.

During interview on 10/02/17, at 2:22 p.m. R130 stated, "I will never forget the day my roommate moved in, I was watching television and he [R162] was brought in by the paramedics." R130 stated it was sometime this year in May, and stated he was never notified that he was getting a roommate by the facility.

Review of R130's medical record did not indicate R130 was notified of a new roommate.

R48's quarterly MDS dated 06/17/17, identified she was cognitively intact with no behaviors.

During interview on 10/01/17, at 3:59 p.m. R48 stated she has had at least five new roommates and was not notified of any new roommates prior to them moving in.

Review of R48's medical record did not indicate R48 was notified of new roommates.

During interview on 10/05/17, at 11:41 a.m. the director of social services (DSS) stated if they do a room change they give them seven days notice. The DSS stated the facility tries to let the residents know if they get a new roommate but do

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not always let them know. The DSS further indicated they do not document in the medical record if they had or had not been informed the resident of a new roommate.

A facility policy Procedure Room and Roommate Change effective January 2017, indicated: "notify the attending physician, all departments of the room and/or roommate change, and resident(s) receiving the roommate." The Procedure further indicated to monitor each resident's adjustment to the change in room and/roommate to account for adjustment issues.

SUGGESTED METHOD OF CORRECTION: Social Service and/or designee could review/revise facility policy for room changes, educate responsible staff to assure that roommate changes and/or admissions are relayed to all residents who will be sharing a room with another. The facility could conduct audits of room/roomate changes in the facilty to ensure timeliness of notice of room/roomate changes and ensure resident satisfication with room/roomate changes.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

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| 2 560 | MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents | 2 560 | | 11/13/17 |

Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident

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| 2 560 | Continued From page 23<br>assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R7) with respiratory failure, and 1 of 3 residents (R108) reviewed with behaviors.<br><br>Findings include:<br><br>R7's Admission Record, dated 9/14/17, identified diagnoses of morbid obesity with alveolar hypoventilation (a failure of the lungs to oxygenate adequately), obstructive sleep apnea, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia. R7's admission Minimum Data Set (MDS) of 8/16/17, indicted intact cognition and identified use of oxygen both prior to and during the stay at the facility. The MDS also identified R7 had use of BIPAP/CPAP (a device used to aid sleep apnea) both prior to admision and following the admission to the facility.<br><br>During observation on 10/1/17, at 9:57 a.m R7 was noted to have oxygen in place via a nasal cannula with liquid oxygen while up in wheelchair. R7 stated she was admitted to the facility on 8/9/17, however, was hospitalized on 8/19/17, related to respiratory problems and sepsis (an infection). She used oxygen therapy and a BIPAP prior to admission to the facility.<br><br>A review of the nursing progress notes identified R7 was hospitalized on 8/19/17. The admission | 2 560 | Corrected | |

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history and physical (H&P) identified R7 was admitted with respiratory failure and septic shock. The Discharge Summary of 8/26/17, noted R7 was hospitalized with diagnosis of acute on chronic respiratory failure. The document identified R7 was experiencing septic shock, acute psychosis, transaminitis (abnormal lab value indicating liver failure) due to a shocked liver.

A review of R7's Medication Adminsitration Record (MAR) and the Treatment Administration Record (TAR) were conducted and although the records initially identified the use of CPAP/BIPAP, it did not provide any specifications as to which settings are used or what to monitor on the machine for settings. The directions only outlined cleaning of the mask, humidifier bottle, and filling of the humidifier bottle.

R7's care plan, revised 8/17, listed R7 had a potential for nutritional problem, due to multiple medical problems, and respiratory status. However, the care plan did not direct staff to complete specific monitoring of R7's lungs, oxygen saturation levels, how many liters of oxygen to use, or what symptoms to monitor to identify any changes or decline in respiratory status.

On 10/4/17, at 9:49 a.m. the assistant director of nursing (ADON)-B confirmed R7's current care plan and confirmed the care plan did not identify any respiratory problems or necessary interventions, with the exception of how it may have impacted her nutrition. She confirmed R7 had been recently hospitalized for respiratory problems. The ADON-B stated this should be included in the resident's care plan and should have been reviewed and updated following her

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return from the hospital.

R108's facility face sheet, undated, identified R108 had diagnoses of intracranial injury, psychotic disorder, paraplegia disorder, schizoaffective and bipolar disorder. R108's quarterly MDS dated 7/24/17, identified he had intact cognition, disorganized thinking, verbal altercations and needed staff assistance for activities of daily living. The behavior Care Area Assessment (CAA) worksheet dated 2/24/17, identified resident displayed delusions and hallucinations which could cause behavior problems.

During observation on 10/3/17, at 10:12 a.m. R108 was yelling in the entry way of the nursing home at (R71 and R201) stating, "Look at yourself in the mirror and you will see the definition of ugly," and R71 yells back. Social Service (SS)-B whom was in the area talks to R71 who is very upset yelling (R108) calls us names all the time and nothing happens, R71 leaves the area. R108 remained in area after the confrontation, looking around, no one talked with R108 about his yelling at R71. At 10:16 a.m., four minutes later, R71 was outside of the administration office yelling at executive director (ED), and assistant executive director (AED)-A, AED-B and director of quality. R71 very upset yelling, he was "tired of him [R108] yelling'" and calling him "an Indian", and (R201) a "Nigger". You have not done anything about this, and I am tired of it. All you tell (R108) to do is calm down, nothing gets done and I am sick of it. You have no idea what I or (R201) have gone through when we get called those's names. "I am sick of it!" The ED, and AED-A tried to calm R71 down. R71 kept telling administration (R108) "bums

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cigarettes" from (R192) all the time. I have heard him get mad at her, she doesn't like it when (R108) goes off on people, so she gives into him and he gets 3-4 cigarettes a day from her. While R71 was yelling at administration. R108 was sitting in his wheelchair approximately 15 feet away, smiling and grinning with enjoyment while watching R71 yelling at the facility administraiton staff.

R108's Mood and Behavior Assessment Care Plan review on 8/8/17, identified bipolar affective disorder, and used antipsychotic medications, and antianxiety medications. The interventions included, monitor for side effects, periods of altered perception or awareness, disorganized speech, lethargy, changed in cognitive level, hallucinations and constipation. There were no staff interventions idenfied to assist staff on how to deal with R108's behavior of being demanding, using profanity and name calling of other residents to help decrease these behaviors.

During interview on 10/4/17, at 9:23 a.m. with ADON-A and SS-A both stated, R108 has lots of verbal behaviors of yelling at staff and residents with very "colorful" words. He sees ACP on a regular basis but also refused to see them as well, his main focus is cigarettes with his behaviors. Associated Clinic Psychology (ACP) told us to develop a cigarette plan, and roll his cigarettes so his money lasted longer and this would stop him from bothering other residents. He started to sell them to other residents, then he complained they were not packed right and did not like the taste, so he (R108) stopped this program at the end of June 2017. We have not implemented any other behavior plan, or care plan for R108, we just do our best.

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| 2 560 | Continued From page 27<br>A policy titled Care Plans, revised January 2017, identified the care plan: "Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practible level of well being." The procedure identified under bullet one: "Initate the appropriate Care Plan according to the RAI (resident assessment instrument) process and as needed with resident change in condition.<br><br>SUGGESTED METHOD OF CORRECTION: The director or nursing and/or designee could educate responsible staff in creating resident-centered care plans, utilizing resident comprehensive assessments.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 560 | | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure care plan interventions was implemented as directed for 2 of 3 residents (R134, R121) who required staff assistance for repositioning; 1 of 1 resident (R121) whom required range of motion. In | 2 565 | Corrected | 11/13/17 |

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addition, skin monitoring not completed for 1 of 2 resident (R6) with a current pressure ulcer and activities of daily living (ADL's) were not completed for 3 of 5 residents (R183, R55, R2) dependent upon staff for ADL's.

Findings include:

REPOSITIONING:

R134's significant change Minimum Data Set (MDS) dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with bed mobility, transfers and toileting. The MDS further indicated he was at risk for pressure ulcers and had no pressure ulcers.

R134's Skin Integrity Assessment: Prevention And Treatment Plan Of Care dated 10/03/17, indicated he required frequent turning, and was to be repositioned every two hours and to provide a pressure relief surface. In addition the care plan indicated he was incontinent of bowel and bladder. R134's Actual/Potential For Infection Care Plan dated 10/17, indicated he had a history of urinary tract infection and had a foley catheter.

During continuous observation 10/03/17, from 8:35 a.m. to 11:07 a.m. ( 2 hours and 32 minutes) R134 was observed to be sitting in his Broda chair (tilt and recline positioning chair), without being repositioned/toileted or checked/changed. At 8:35 a.m. R134 was observed across from the nurses station on the first floor, at 9:00 a.m. R134 was moved across from the nurses station in the hall, at 9:12 a.m. R134 was asleep in the Broda chair, at 9:30 a.m. registered nurse (RN)-K hospice nurse moved R134 from the hall to the dinning room. At 10:02 a.m. RN-K hospice nurse moved R134 back into the hall across from the

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nurses station. At 10:22 a.m. R134 was asleep in the hall in his Broda chair. At 10:42 a.m. R134 was still in hallway in chair asleep. At 11:00 a.m. he was still asleep. At 11:07 a.m. surveyor informed nursing assistant (NA)-M and NA-J of findings.

During interview 10/03/17 at 11:01 a.m. NA-N stated that he had repositioned and checked him for bowel incontinence right after breakfast around 8:30 a.m.

During interview 10/03/17, at 11:12 a.m. NA-M stated she had assisted NA-N right after breakfast with repositioning R134. She indicated she did not have a chance to reposition him again because they did not have enough staff and that he needed assist of two so she could not reposition him timely.

During observation 10/03/17, at 11:30 a.m. (a total of 3 hours) NA-J and NA-N was observed to reposition and check R134. R134 was continent of bowel and had a catheter for urine. In addition R134's skin was intact with no open areas or redness of the skin.

Although R134's care plan indicted he was to be turned and repositioned every two hours the facility failed to implement his care plan and R134 went approximately three hours without being repositioned.

R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent upon and required the physical assistance of two staff for

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bed mobility, eating, dressing, toileting and personal hygiene. The MDS indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue).

R121's "Skin Integrity Assessment: Prevention and Treatment Care Plan", dated 4/17, identified pressure ulcer to coccyx, and directed a turn and reposition program with a frequency of "Q2" (every) two hours.

During observation on 10/3/17 at 11:32 a.m., R121 was lying in bed in his room, dressed in a gown and covered with a white sheet, to which a call light was clipped. An alternating pressure mattress was on the bed and running, and set at "4". R121 was laying on his back, facing the exit side of bed, with a pillow visible from under the cover, slightly lifting his left, back side. Under the covers, the shape of a pillow was seen, placed between R121's legs, as well as heel boots placed bilaterally on R121's feet.

During continuous observation from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed remained unchanged. At 1:58 p.m., nursing assistants (NA)-D and NA-B entered R121's room, closed the door behind them, and announced to R121 they were going to "check you" and "reposition you." Working on each side of R121's bed, NA-D and NA-B raised the bed to a working height, and began their cares, talking with R121 as they preceded. R121's brief was checked and was not wet. NA-B removed the pillow from under R121's left side, and NA-D took out the pillow between his legs. Together NA-B and NA-D pulled R121 up in bed, then refitted the pillows between his legs, and now placed R121 slightly facing the window, with a pillow under R121 right back side. The

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pillow between R121 legs was replaced, and legs adjusted, then R121 was covered with the bed sheet. Before NA-B and NA-D exited the room, they removed gloves and washed their hands.

During an interview on 10/3/17 at 2:06 p.m., nursing assistant (NA)-D stated the last time R121 was "done" (repositioned) was at 11:30, and now it was two o'clock. NA-D stated we got busy down there, and that (R121) should be checked and turned every two hours. NA-D stated "it was late."

When interviewed on 10/3/17 at 4:30 p.m., registered nurse (RN)-B stated it was his expectation that residents be turned "timely" so that the wound can be taken care of an not break down more. RN-B stated R121 had a open, stage 4 pressure ulcer, and also it was "not acceptable" that R121 was not turned as he was supposed to be. RN-B stated he thought some of the aides needed more training and needed to be more aware of the residents' care needs.

When interviewed on 10/4/17 at 8:52 a.m., the assistant director of nursing (ADON)-C stated she "would expect" R121 to be turned and repositioned every 2 hours as care planned.

RANGE OF MOTION

R121's Restorative Program History report, printed 10/4/17, indicated R121's passive ROM program goal to be: Resident will maintain current range of motion with assistance of doing PROM to bilateral extremities twice a day for 15 reps each time. The program directed: 1. Explain procedure; 2. Perform PROM to bilateral lower extremities and; Report to nurse any

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complaints of pain, refusals. R121's mobility care plan, dated 4/17, identified contractures and muscle stiffness as a target problem.

During observation on 10/3/17 at 8:18 a.m., R121 was lying in his bed in his room, facing the window, a pillow under his left side. R121's arms were at his side, elbows folded and forearms at 45 degree angle from his elbow, and situated upon his stomach. R121 wore heel boots, bilaterally, on his feet. During continuous observation from 8:18 am to 11:32 a.m., R121 remained lying on his bed in his room. At 9:29 a.m., nursing assistant (NA)-D and registered nurse (RN)-B repositioned R121. At 11:32 a.m., RN-B, NA-D and NA-B assisted with R121 with a dressing change and repositioning. At 1:58 p.m., R121 was again repositioned by NA-B and NA-D. R121 was not offered nor was provided any range of motion during any of the visits by nursing staff.

During interview on 10/3/17 at 2:06 p.m. NA-D stated she assisted R121 only to reposition and did not do any kind of ROM exercises. NA-D stated she "did not think" R121 has any range of motion or exercise program.

When interviewed on 10/3/17 at 4:38 p.m., RN-B stated R121 did not have any orders for restorative nursing, however, R121 could benefit from a ROM program, so (R121) could keep his arms and hands "more limber."

During observation of the morning routine on 10/4/17 at 9:42 a.m., NA-A and NA-C assisted R121 with morning cares, including repositioning and oral cares. There was no provision or offer to complete range of motion for R121 during the morning routine. When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a

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range of motion program, and has not assisted him with that. NA-C stated often therapy often worked with res in their rooms, but has not seen anyone work with R121 in his room. NA-C stated she did not perform ROM for R121.
During an interview on 10/4/17 at 9:59 a.m., NA-A stated she did not think R121 had any range of motion program, and if he did, we would have had "someone from therapy" show us what to do. NA-A stated she did not help R121 with any exercise or range of motion.

When interviewed on 10/4/17 at 8:43 a.m. the assistant director of nursing (ADON)-C stated R121 had a restorative program and futher the aides should be completing that task, during cares or when repositioning. ADON-C questioned how R121 could be 'refusing' the program because of his current disposition and stated the ROM program was to be completed twice daily, 15 reps each time. ADON-C also stated the instructions for restorative program in the care tracker were part of the care plan, and she "expected" R121 to receive range of motion services as identified.

LACK OF SKIN MONITORING:

R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs), had unhealed pressure ulcers and remained at risk for further pressure ulcer development.

R6's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 8/7/17, identified R6 was at moderate risk of pressure ulcer development and had a history of past pressure ulcers. The care plan listed several interventions

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including keeping his skin clean and moist, encouraging him to reposition every two hours and, "Complete Push [Pressure Ulcer Scale for Healing] Tool Weekly."

R6's medical record was reviewed and lacked any completed PUSH tools as directed by R6's care plan.

During interview on 10/3/17, at 2:33 p.m. RN-A stated a care plan was used to, "direct us," in how to provide care for a resident, and staff should be implementing the interventions. RN-A stated the PUSH tool was used to help determine if the wound was, "getting bigger, getting worse or stalled." Further, RN-A stated the PUSH tools were not currently being completed, "at this moment," but would be on a weekly basis going forward.

When interviewed on 10/4/17, at 1:37 p.m. the interim director of nursing (DON) stated a care plan was used to, "keep all staff informed," of resident needs and staff were expected to keep abreast of the interventions listed on it. Further, the DON stated the PUSH tool was considered part of a comprehensive skin assessment and could help determine if new interventions were needed for a pressure ulcer.

ADL'S NOT PROVIDED:

R183's Admission Record, dated 10/5/17, identified multiple medical diagnosis including heart failure, diabetes, morbid obesity, hypertension, lymphedema, chronic respiratory failure and urinary retention.

R183's admission Minimum Data Set (MDS) completed on 8/3/17 identified resident was

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cognitively intact with moderate symptoms of depression. R183 required extensive assistance of one to two staff to complete ADL's including dressing, grooming, bathing, toileting and mobility.

A review of R183's care plan noted initiated 7/28/17 identified R183 required personal assistance with personal hygiene/grooming/dressing/undressing.

During observation and interview on 10/1/17 at 3:44 p.m., R183 was resting on his bed, covered only with a sheet. R183 stated he was dependent on staff for provision of care, stating " I can turn my light on, but I don't know how long it will take them to come." R183 did acknowledge he had called 911 when he had been left on the commode for 45 minutes. He stated the staff responded within five minutes after he called 911. R183 stated his bath is scheduled for Mondays, but had not yet received since admission to the facility which was more than two months ago. R183 stated to receive a shower he would need to be transported on a gurney and assisted to shower while on the cart. R183 stated he has received a "A whore bath", when he was assisted to wash up with a basin. R183 was noted to have a strong, foul odor of perspiration and other body odors.

During observation and interview on 10/2/17, at 12:23 p.m. R183 stated he was going to get dressed today but didn't feel real clean and his last bed bath was about two weeks ago. R183 was dressed in a hospital gown at this time and was noted to have a increased personal odor of perspiration and other more personal odors than had been noted during observation on 10/1/17. The personal odor was very prominent in the

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room, and lingered into the hallway. R183 stated he chose note to get up for lunch today because it took too long to get back to bed, he was uncomfortable and has had a history of pressure ulcers. Following this interaction, the facility bath schedule was posted at the nurses station and identified R183 received his bath on Tuesday evenings.

During interview on 10/4/17, at 7:05 a.m. R183 stated he had received a bed bath last evening (10/3/17). After his bedbath he requested to get up out of bed and was asked why he wished to get up. R183 stated he had to instruct staff to change his bed linens following his bath because he wanted fresh bed linens. R183 stated linens were changed as requested.

During interview on 10/4/17, at 2:19 p.m. nursing assistant (NA)-S stated he had provided assistance to provide a bedbath for R183 and stated they provided care according to the care plan. R183 could request what he wanted. NA-S stated when providing routine cares, and not a bedbath, it is important to provide catheter care, emptying the catheter, and performing hygiene to the catheter.

A review of the physician progress notes of 10/2/17 identified R183 did not wish to pursue catheter removal, noting "I can't even get someone here to help me shit. I won't be demeaned any further."

During interview on 10/5/17 at 9:59 a.m. the assistant director of nursing (ADON)-B stated R183 was very impatient and went on to state if he does not receive immediate assistance, he will attempt to self transfer, or call 911. ADON-B stated the call light should be answered

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immediately, with assistance provided within ten minutes, however, it may take longer to summon adequate staff to provide assist of two for transfers. ADON-B stated she was unaware of concerns regarding personal odors, and expressed it was the expectation residents are washed up with morning and bedtime cares, including washing of face, hands, pericare, armpits, and application of lotion and deodorant. ADON-B stated residents hair are routinely washed on bath day. The resident care tracker was reviewed from 9/28/17 through 10/3/17, with notations made resident had received two bedbaths in one day. ADON-B stated he wouldn't gotten two in a day ADON-B stated if short staffed, and they are unable to complete it, the task would be passed on to the oncoming shift to complete. The ADON-B state it would be appropriate for him to be washed up and receive a bath at the time the odor was noted.

R55's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. Diagnoses included dementia and depression.

R55's ADL/Mobility care plan last dated 4/10/17, included a goal for R55 to be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene and dressing.

On 10/1/17, 9:50 a.m. R55 was seated in her wheelchair in the doorway to her room. A dark brown substances was noted to be under her long fingernails on her right hand.

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During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap.

On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.

During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)- A stated nail care should be done daily with cares if visibly dirty, otherwise weekly with their showers. ADON-A stated residents should not be sitting in urine soiled clothing. ADON-A stated R55's care plan should have been followed.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently incontinent of urine, with moisture associated skin damage and diagnosis was schizophrenia.

R2's ADL/Mobility last reviewed on 8/5/17, indicated R2 would be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADL's and at times refused shaving. The care plan lacked approaches to refusal of cares.

During observation on 10/2/17, at 2:10 p.m. R2

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was standing at the nursing desk and had a strong urine smell. His sweat pants were saturated with urine in the front and back, as well as the right lower side of his shirt. Multiple staff were located around the nursing desk and no staff members offered to assist him with toileting. R2 hair was uncombed and sticky up in multiple places. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated with urine. R2's room had a strong odor of urine present that could be smelled in the hallway.

On 10/3/17, at 10:12 a.m. R2 was walking in the hallway in front of the nursing desk, his shoes were untied, his hair was uncombed and sticking up in multiple places, his gray t-shirt had a tear in the back of the color from one side of the neck to the other. ADON-A approached R2 and offered to tie his shoes. R2 allowed ADON-A to tie his shoes; however ADON-A did not offer to take him back to his room and help him change his shirt or comb his hair.

On 10/4/17, at 6:51 a.m. R2 was sitting in the dining room watching television. His hair was uncombed and was sticking up in multiple places. His gray t-shirt had a quarter sized hole in the front. R2 was in the dining room until 9:06 a.m. when he walked down the hall towards his room and laid in bed. Staff did not approach R2 and offer to change his shirt or comb his hair, during this time.

During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are

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aware when R2 was soiled,and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and wasn't sure who did.

During interview on 10/5/17, at 9:39 a.m. ADON-A stated R2's current care plan needed to be looked at for revisions; however staff did not follow the current care plan and should have. ADON-A stated R2's care plan directed staff to physically assist with personal hygiene, grooming and dressing.

The facility policy Care Plans dated 7/15, indicated " The center follows the CMS RAI philosophy and process on care planning. The comprehensive care plan should be an interdisciplinary
communication tool that must have measurable objectives with time frames and describes the services to be provided to attain or maintain the resident ' s highest practicable physical, mental and psychosocial wellbeing. The care plan must be reviewed and revised according to the RAI process, and services provided or arranged must be consistent with each
resident ' s written care plan...Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident ' s function status."

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could educate all floor staff in the utilization and implementation of the residents' comprehensive care plan when providing care.

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| 2 565 | Continued From page 41<br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 565 | | |
| 2 570 | MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision<br><br>Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to revise the care plan to include specific feeding instructions for 1 of 1 residents (R19) identified with swallowing difficulties received safe and appropriate assistance with eating. In addition, the facility failed to revise the care plan to include an indwelling catheter for 1 of 2 residents (R48) reviewed for justification of use for a catheter.<br><br>Findings include:<br><br>R19's Admission Record, undated, indicated that he had dementia and dysphagia. R19's Minimum Data Set (MDS)dated 09/08/17, indicated he needed extensive assist of one with eating and had no swallowing disorder. R19's Care Area | 2 570 | Corrected | 11/13/17 |

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| 2 570 | Continued From page 42<br><br>Assessment (CAA) dated 09/08/17, indicated that he required assist with feeding at meals and tolerated a mechanically altered diet. The CAA further indicated he had vision problems, a need for special diet or alerted consistency had inability to perform physical assistance, had availability of sufficient eating assistance and availability of and proper positioning in wheelchair for dining.<br><br>A Discharge Summary Note dated 11/30/16, indicated R19 had aspiration pneumonia, and x-ray with bilateral infiltrates.<br><br>R19's Nutrition Risk Care Plan dated 09/08/17, indicated he received a pureed diet with honey thickened liquids and needed total assist with dining room and remind of meal times. The care plan did not list specific speech therapy recommendations. R19's diet card indicated that he needed total assist to be fed and he received honey thickened liquids and a pureed diet. In addition, R19's nursing assistant care sheet indicated his liquids were honey thickened, needed total assist with eating and see ST (speech therapy) instruction.<br><br>R19's speech therapist note dated 08/02/17, indicated PT (patient) seen for skilled ST services to address dysphagia (difficulty swallowing) and complete final session to receive discharge documentation. Therapist followed up with nursing staff regarding use of printed compensatory swallowing strategies to reduce aspiration risk. A 24-hour log updated for discontinuation of services due to inability to progress due to dementia and inability to follow cues. Nursing staff to implement use of compensatory swallowing strategies and monitor for ongoing signs and symptoms of aspiration. | 2 570 | | |

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A 24 Hour Status Report dated 08/02/17, indicated: "D/C [discontinue] from ST today continue puree/honey thick liquid diet. Printed strategies at patients table to follow during meals."

The speech therapy instruction sheet indicated the following:
* Bite sizes should be 1/2 spoonful of puree
* Use spoon to give honey thickened fluids (1/2 spoon size)
*Allow patient to clear mouth completely before giving another bite
* Do not put more food in patient's mouth if he is still chewing
* If he begins coughing, do not give more food until coughing discontinues.

R19's care plan lacked the specific feeding instructions indicated by the speech language pathologist (SLP)-A.

R48's Urinary Incontinence and Indwelling Catheter CAA dated 3/27/17, indicated R48 was occasionally incontinent of urine and did not have an indwelling urinary catheter.

R48's progress note dated 5/1/17, at 9:00 p.m. indicated R48's hospice nurse inserted a Foley catheter and was to be maintained by hospice.

R48's quarterly MDS dated 6/17/17, indicated R48 had an indwelling catheter.

On 10/3/17, at 9:37 a.m. R48 was observed in her room to have a catheter attached to her right leg draining yellow urine.

R48's urinary continence care plan dated 8/7/17,

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| 2 570 | Continued From page 44<br>indicated R48 was occasionally incontinent of urine. The care plan did not indicated R48 had a Foley catheter.<br><br>During interview on 10/5/17, at 10:14 a.m. assistant director of nursing (ADON)- A stated R48's care plan should have been revised to reflect the use of a Foley catheter, and list interventions for staff to maintain the catheter.<br><br>The facility policy Care Plans dated 7/15, indicated: "The center follows the CMS RAI philosophy and process on care planning. The comprehensive care plan should be an interdisciplinary communication tool that must have measurable objectives with time frames and describes the services to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing. The care plan must be reviewed and revised according to the RAI process, and services provided or arranged must be consistent with each resident's written care plan."<br><br>SUGGESTED METHOD OF CORRECTION: The director or nursing and/or designee could educate responsible staff in revising comprehensive care plans, utilizing resident comprehensive assessments. The DON or designee could conduct audits of cares according to the individual resident care plans to ensure the individual resident needs are being met.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 570 | | |
| 2 800 | MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements | 2 800 | | 11/13/17 |

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| 2 800 | Continued From page 45<br><br>Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 of 5 residents (R55, R2, R183) whom were dependent upon staff for ADL's, 2 of 4 residents (R134, R121) reviewed for pressure ulcers, for 1 of 2 residents (R121) reviewed for range of motion, 2 of 2 residents (R19, R97) reviewed for paid feeding assistant, and 16 residents (R48, R28, R196, R180, R162, R47, R6, R31, R24, R82, R130, R192, R43, R31, R66, R183) and 14 staff members (RN-C, HUC-A, NA-C, RN-E, RN-G, ADON-A, HN-A, LPN-E, LPN-I, NA-E, NA-G, NA-H, ADON-C, AS) whom voiced concerns with the lack of sufficient nursing staff in the facility. This had the potential to affect all 94 residents in the facility.<br><br>Findings include:<br><br>ADL's NOT MET:<br>R55 was observed on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair with a strong smell of urine and had a saturated wet area of her lap. R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting | 2 800 | Corrected | |

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with her. At 11:18 a.m. the social services director (SSD) brought R55 onto the elevator and brought outside for cigarette. SSD did not address R55's urinary incontinence.

R2 was observed on 10/2/17, at 2:10 p.m. standing at the nursing desk with a strong smell of urine. His sweat pants were wet in the front and back, as well as the right lower side of his shirt. Multiple staff were located around the nursing desk and no staff members offered to assist him with toileting. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated. R2's room had a strong odor of urine present that lingered into the hallway. During interview on 10/4/17, at 9:12 a.m. NA-G stated they were aware of R2's needs but were unable to assist R2 due to the lack of staffing.

R183's admission MDS dated 8/3/17, identified R183 had intact cognition and required extensive assistance to complete all ADL's except eating. On 10/1/17, at 3:44 p.m. R183 while laying in bed had a strong, pungent odor of perspiration and other body odors. He stated he had not yet received one bath since admission to the facility greater than two months ago.

PRESSURE ULCERS
R134's Skin Integrity Assessment: Prevention And Treatment Plan Of Care dated 10/03/17, directed staff to reposition R134 every two hours. During continuous observation 10/03/17, from 8:35 a.m. to 11:07 a.m. (2 hours and 32 minutes) R134 was observed to be sitting in his Broda chair (tilt and recline positioning chair), without being repositioned/toileted or check and change. At 11:07 a.m. surveyor informed nursing assistant (NA)-M and NA-J that R134 had not been

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repositioned for over 2 hours and 30 minutes. NA-M stated she had assisted NA-N and they do not have enough staff to reposition resident timely.

R121's Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent and required the physical assistance of two staff for bed mobility, and toileting and had a current pressure ulcer. During continuous observation on 10/3/17, from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed which remained unchanged. During an interview on 10/3/17, at 2:06 p.m., nursing assistant (NA)-D stated we got busy, and R121 should be checked and turned every two hours.

ROM
R121's Restorative Program History report, printed 10/4/17, identified R121 was to receive passive range of motion (ROM). During interview on 10/2/17 at 6:22 p.m., family member (FM)-C stated R121 was not getting his ROM program exercises. When she visits, she completes the ROM for R121, and has been rolling towels and placing them in his hand to keep them from rolling up and getting tight. When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a range of motion program, and has not assisted him with that.

ASSISTANCE WITH EATING
During interview 10/04/17, at 9:22 a.m. HR-A stated she had been working at the facility since 03/07/17, and became a NA in 2005, her NA certificate had expired in 2008, and she had not renewed her certificate. HR-A stated she assists with feeding when they are short staffed and has assisted R19 and R97.

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| 2 800 | Continued From page 48<br><br>RESIDENT COMPLAINTS REGARDING STAFFING CONCERNS:<br>R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact, had an indwelling catheter and required extensive assistance to toilet. During interview on 10/1/17, at 3:55 p.m. R48 stated she needed to empty her own catheter and make her own bed because it took staff one to two hours to answer her call light. Further, R48 stated she had to fight with the facility to allow her nitroglycerin (medication used to treat chest pain) to be left at the bed side, because it took so long for staff to come and administer them medication when she was having chest pain.<br><br>R28's quarterly MDS dated 6/20/17, indicated R28 was cognitively intact and required extensive to total dependence with ADL's. On 10/1/17, at 4:10 p.m. R28 stated he was unable to get in and out of bed when he liked. Four days out of the week it was common to wait over 30 minutes to get assistance.<br><br>R196's admission MDS dated 9/16/17, indicated R196 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 12:19 p.m. R196 stated she had to wait an hour while being on the bed pan and it was uncomfortable. R196 stated the staff put her on the bed pan, leave and tell you to put the call light on and then don't return when the call light is put on.<br><br>R180's quarterly MDS dated 9/13/17, indicated R180 was cognitively intact, required supervision for ADL's and received scheduled and as needed pain medications. On 10/2/17, at 12:25 a.m. R180 stated staff often didn't answer call "buttons" for and hour or two, and when they finally answered | 2 800 | | |

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the light he often was told "I'll tell the nurse." R180 stated it can take a long time to get pain medications, sometimes 45 minutes. The nurses then "make up all kinds of excuses" why they are late.

R162's quarterly MDS dated 8/17/17, indicated R162 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 12:35 R162 stated there was a 20 percent chance your call light will be answered timely. The answer your light and say they need to go get someone to help, then the staff walk out and no one comes back. I was told by a nursing assistant if I needed assistance during lunch I would need to wait, because they were so understaffed there was not anyone to answer call lights during lunch. R162 also stated he was not always getting bathed do to the lack of staff.

R47's admission MDS dated 9/18/17, indicated R47 was cognitively intact and required extensive to total dependence from staff for ADL's. During interview on 10/2/17, at 12:37 p.m. R47 stated staff were so rushed there were not cleaning under his foreskin.

R6's quarterly MDS dated 8/11/17, indicated R6 was cognitively intact and required extensive assistance with ADL's. When interviewed on 10/2/17, at 1:19 p.m. R6 stated there was not enough staff, and has waited an hour to an hour and a half to have his call light answered. R6 added staff sometimes didn't even answer the call light.

R31's annual MDS dated 7/24/17, indicated R31 was cognitively intact and required extensive to total dependence of staff for ADL's. On 10/2/17,

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at 1:19 p.m. R31 who resided on 1st floor stated there were only two to three nursing assistants scheduled on the floor, and it was not enough, as most of the residents on that floor required two staff members to assist with cares and transfers. When staff take their breaks that leaves only one or two staff members on the floor. There is a lack of help during meal times and you can't get assistance to toilet during meal times. He is incontinent two to three times a week, do to the lack of assistance by staff.

R24's quarterly MDS dated 9/1/17, indicated R24 was cognitively intact and required extensive to total dependence of staff for ADL's. When interviewed on 10/2/17, at 1:28 p.m. R24 stated there were not enough nursing assistants and had to wait a half hour or more to have call lights answered. Also at times the call light would be answered and shut off, staff say they would be back and don't come back for two hours. This has happened while being on the bed pan and it "made me very angry." R24 also stated they have been incontinent waiting for staff assistance. I don't feel they have enough staff, and they need more people to take care of the residents. Staff are leaving because of the heavy workload.

R82's annual MDS dated 6/27/17, indicated R82 was cognitively intact and required extensive to total dependence of staff for ADL's. During interview on 10/2/17, at 1:30 p.m. R82 stated the facility was always short staffed. The management said there was a low census, so they couldn't schedule more staff. R82 stated she needed to wait over an hour at times to have her incontinent product changed. R82 stated that happened at least four times a week and it was worse on the day shift. "I hate even going to the bathroom during the day, because I know I will

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have to wait."

R130's quarterly MDS dated 8/15/17, indicated R130 was cognitively intact and required extensive assistance with ADL's. During interview 10/01/2017, at 10:17 R130 stated he had been at the facility for about a year. I hate it here I don't like the staff, I don't like the food. I don't like the staff, they are always understaffed. I takes them forever to answer the call light I wait 45-min to an hour for help. I have had a accident waiting for help that makes me feel horrible. I wear a brief but would like to use a urinal I have to put on my call light on for them to bring the urinal. When interviewed on 10/2/17, at 2:19 p.m. R130 stated he did not feel there was enough staff in the facility and at times waited 30 to 45 minutes, so I want my urinal and when they don't come I have wet myself and it doesn't make me feel good.

R192's admission MDS dated 9/6/17, indicated R192's was cognitively intact and required extensive assistance with ADL's. On 10/2/17, at 2:28 p.m. R192 stated she has put her call light on and no one answers it for 25 minutes or more.

R43's quarterly MDS dated 8/17/17, identified R43 had intact cognition, required extensive assistance with activities of daily living (ADLs) and had, "total dependence," on staff for transfers. During observation on 10/3/17, at 8:47 a.m. R43 was seated in a wheelchair outside her room with her call light turned on. At 8:54 a.m. (seven minutes later) R43 remained in the wheelchair outside her room. RN-E approached R43 and stated, "Are you waiting for someone to lay you down?" R43 responded she was but, "they [staff] just walk right on by." RN-C stated she would tell staff and walked away. When

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| 2 800 | Continued From page 52<br>interviewed immediately following, R43 stated, "I just want to lay down," as she was having pain in her right leg, however, "I don't get help." Further, R43 stated she has waited so long before to get assistance with laying down, "I have one of my anxiety attacks." R43 remained seated in her wheelchair in the hallway until 9:04 a.m. (17 minutes later) when an unidentified NA approached her with the mechanical lift machine and assisted her to lay down.<br><br>R31's annual MDS of 7/24/17 identified resident exhibited intact cognition with no signs of delirium. R16 was noted to require extensive assistance of one to two staff to complete ADL's including transferring, position, dressing, grooming and bathing. During interview on 10/2/17 at 12:52 p.m. R31 stated "You get a chance to get a bath once a week or a shower. When they are short staffed, they give a bed bath, which is just a wash down which they should do everyday. R31 stated at times it had been, "Three weeks in a row that I didn't receive a bath." R31 stated it is difficult when there are only two staff on the floor and it takes two staff to complete a shower. If there is not enough staff when you have your scheduled shower day, it gets missed.<br><br>R66's quarterly MDS completed on 9/3/17, indicated R66 exhibited no cognitive impairment and required total to extensive assistance with the activities of daily living (ADL's), including dressing, grooming, bathing and mobility. During interview on 10/1/17, at 4:10 p.m. R66 expressed concern regarding staffing, stating assistance with bathing occurred infrequently. R66 stated if they are short staffed "You don't receive a bath." R66 went on to say he had received assistance to wash his hair on only three | 2 800 | | |

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occasions in the last year and a half. When placing the call light on to summon assistance, it is not a guarantee you will get help. Staff will often turn off the call light and say that they will come back, but often don't return, or return after an extended period of time.

R183 stated on 10/1/17, at 3:36 a.m. R183 stated the facility was understaffed. He had been incontinent of bowel and it took over an hour for staff to assist him. R183 stated at one time her called 911 because the staff had left him on the commode for 45 minutes and it "pissed" him off. Further, he needed to wait long amounts of time to be put to bed and had a pressure ulcer on his buttocks and need to lay down and not wait for staff. R183 stated on 10/05/2017 9:24 a.m a couple of weeks ago, there were only two aides on the floor all day and the evenings. "When you short staff us, we all suffer," and we are not getting the care we need.

STAFF CONCERNS REGARDING STAFFING CONCERNS
Registered nurse (RN)-C stated on 10/1/17, at 10:01 a.m. due to the allowed staffing in the facility, nurses tried hard to get there medication passes completed, however, treatments were not consistently being done as ordered. RN-C further stated the four nursing assistants and two nurses working the cart was not enough staff to meet the resident needs on the 4th floor.

Health unit coordinator (HUC)-A stated on 10/3/17, at 11:02 a.m. the staffing on 4th floor was "horrible." Sometimes the resident needs were not being met as there were a lot of residents that needed two people to assist them. HUC-A added when the staff were in rooms assisting other residents, the residents who had

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there call lights on waiting for assistance start yelling. There used to be five nursing assistant on 4th floor, but now management was only scheduling four nursing assistants. The HUC added R6 frequently called the facility, when staff did not answer the call light. R55 was soiled with urine about three to four times a week along with R2. She stated she has directed R2 to his room and changed his urine soiled clothing, because the nursing staff didn't have the time to assist him.

NA-C stated on 10/3/17, at 11:46 a.m. call lights frequently take 30 to 45 minutes to be answered because we are assisting other residents with care and there isn't enough staff. NA-C further stated "that's a long time" to wait to go to the bathroom. NA-C stated resident are frequently incontinent because there are not toileted timely. Maybe if they could be toileted timely they wouldn't be incontinent. The facility will only schedule four aids on the 4th floor and have asked for more staff. The residents are angry with us and think we don't answer call lights timely on purpose.

RN-E stated on 10/3/17, at 2:26 p.m. it can be difficult to get all task completed timely. On 4th floor there are a lot of residents who require two people to assist with cares and when those two people are assisting someone others need to wait. RN-E stated staff can't stop in the middle of a two person transfer to assist someone to change their incontinent product or help someone with toileting.

RN-G stated on 10/3/17, at 2:53 p.m. there are two nursing assistants scheduled to work each wing of the 4th floor, for a total of four nursing assistants. RN-G stated there are at least 11

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residents out of 26 on her wing that require two people for transfers and care and the other wing had a lot higher acuity level. We had a meeting with management one to two weeks ago and we brought up staffing concerns and were told it was not in the budget to add more nursing assistants. The management is not taking into account the level of care these residents need. Some residents are leaving and finding new places to live because their needs were not being met do to the lack of staff.

Assistant Director of Nursing (ADON)-A stated on 10/3/17, at 3:15 p.m. there are not enough aids scheduled in the facility to begin with. Then they call in and the ADON's need to fill in on the floor, doing cares and passing medications and then we get behind on the assessments and care plans. ADON-A stated there are a lot of complaints from residents regarding not enough staff, but we do the best we can. The facility schedules by amount of resident not there care needs. She stated there have been an increase in falls and incontinence issues related to the staffing levels.

Hospice Nurse (HN)-A from North Memorial Hospice stated on 10/03/17, at 9:30 a.m. the fourth floor does not have enough staff. HN-A stated there is a lot of mental illness on that floor and one evening there was a nurse who said she had 52 residents with only a nurse and two trained medical assistance (TMA)'s and you can't meet all of there needs, and had concerns with pain medications not being given as ordered and physician orders not being transcribed.

Licensed practical nurse (LPN)-E stated on 10/03/17, at 2:57 p.m. she works on the first floor and is the only nurse working on the floor. LPN-E

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stated they recently, with in the last month moved five residents from the third floor to first floor and were told they where going to get more staff to now help out but it never happened. LPN-E stated she was supposed to get a trained medical assistant (TMA) to help with medication pass but that didn't happen either.

LPN-I stated 10/03/17, at 3:01 p.m. they do not have enough staff on first floor especially because so many of the residents are bariatric residents (bariatric's is the field of medicine that specializes in treating morbid or extreme obesity) and require assist of two. LPN-I stated she feels bad for the nursing assistance and end up helping them and then drowning in her own work and the patients get mad waiting. LPN-I stated "sometimes I feel my job is impossible". In addition LPN-I stated the aides can't get there charting done.

NA-E stated on 10/4/17, at 12:36 p.m. here were days that staff are not always able to complete their assignments, such as toileting, getting baths completed and shaving done. They are late in helping in the dining room while having to answer lights. NA-E added it is difficult when someone calls in and until a replacement is found they have to work short.

NA-G stated on 10/4/17, at 9:12 a.m. on a daily basis a residents call light can take up to two hours to be answered because we are with other people. The residents get upset and are frequently incontinent. It happens more on the 4th floor. There used to be five aids scheduled on the 4th floor, which was difficult to meet the residents needs, but now they are only scheduling four nursing assistants. Since the health department entered the facility there are way more people up

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her helping, and we still can't get things done timely. Sometimes there are only three nursing assistants on the 4th floor and its "really really hard" and it has been this way last two months. The residents deserve more time to have their basic needs met. Staffing is so bad here in the evening residents are screaming and fighting. Management tells us were are staffed according to our census. NA-G stated it feels like neglect we are neglecting the residents, but it isn't on purpose.

NA-H stated on 10/4/17, at 9:55 a.m. residents whom are a check and change for incontinence they only get changed in the morning and afternoon, because that is all the staff had time to do. There are not enough staff to meet the resident needs.

ADON-C stated on 10/5/17, at 8:58 a.m. assessments required quarterly and when there is a change in condition, along with updates to the care plan, that are not getting done. ADON-C stated she was needed on the floor do to the lack of staff scheduled. We know they assessments and care plans need to be updated, but there is not enough time.

Anonymous staff interview (AS) stated on 10/5/17, 2:20 p.m. there are times that meals have to be delayed 30 minutes or more because there are not enough staff to bring residents into the dining rooms, help pass the meals or assist resident in eating. AS stated the floor staff are busy with other cares, answering call lights and they are short.

Review of the facility grievance log provided by the facility identified the following staffing and customer services concerns:

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- 8/15/17 concerns regarding long wait times for medications
- 8/21/17 concerns regarding long wait times for cares
- 8/30/17 concerns regarding long wait times
- 8/30/17 concerns regarding staff attitude, wait times and residents wandering
- 9/4/17 customer service concerns
- 9/8/17 customer service concerns
- 9/11/17 concerns related to cares and time put to bed
- 9/15/17 concerns regarding wait times for pain medication
- 9/19/17 concerns related to incontinent products and cares
- 9/19/17 concerns related to call light time
- 9/28/17 concerns regarding care concerns
- 9/29/17 concerns regarding cares.

In an interview on 10/4/17, at 10:03 a.m. scheduling coordinator (SC)-A stated staffing is based, for the most part, on the census of each floor. SC-A stated each morning administration and nursing meet to review staffing, and changes are made depending on the needs of each floor. SC-A stated that she is not sure if there is a formula or how it is determined. SA-A further stated the facility hired an additional scheduler, to assist in replacements.

Review of the facility nursing/nursing assistant schedule, from October 1 - October 4th, 2017 identified the following staffing levels:

> 1st Floor: AM Shift 2 nurse and 3 nursing assistants, PM Shift 1 nurse and 3 nursing assistants, Night Shift 2 nurses (Sunday and Monday due to training) with one nurse Tuesday and Wednesday along with 2 nursing assistants (10/1/17 there were 20 residents on this floor)

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> 2nd Floor: AM Shift 2 nurses and 3 nursing assistants, PM Shift 2 nurses and 2 nursing assistants, Night Shift 1 nurse and 2 nursing assistants. (10/1/17 there were 21 residents on this floor)

> 3rd Floor: AM Shift 1 nurse and 1 nursing assistant, PM Shift 1 nurse and 1 nursing assistant, Night Shift 1 nurse with no nursing assistant on Sunday night, however only had 1 nursing assistant Monday through Wednesday night. (10/1/17 there were 5 residents on this floor)

> 4th Floor: AM Shift 4 nurses Sunday and Monday, and 3 nurses Tuesday and Wednesday and 5 nursing assistants on Sunday, but only 4 nursing assistants on Monday through Wednesday, PM Shift 3 nurses and 6 nursing assistants (one a trainee), with only 4 nursing assistants on Monday and Wednesday, and 5 on Tuesday, Night Shift: 1 nurse and 3 nursing assistants. (10/1/17 there were 48 residents on this floor)

During an interview on 10/4/17, at 2:10 p.m. the executive director (ED) stated she was aware that staffing was not optimal, and attempted to schedule extra if there is a call in, which is not always possible. When asked how the facility had been attempting to correct the facility's staffing issues. ED stated that the facility has hired an additional scheduler, who's shifts over lap to help with call-in replacements throughout the day, but stated that the schedulers do not work on the weekends. The ED stated that the assistant director of nursing's (four in total) take weekend call, and have staff scheduling information with to fill weekend call-ins. The ED stated each

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| 2 800 | Continued From page 60<br>morning (Monday - Friday) during "standup," management review the "allocation" of facility staff, so shortages and cares concerns can be addressed. ED stated that they try to schedule extra staff each day so that "call-ins" and "no-shows" so not to impact resident care. ED stated through quality assurance and staff input, the facility is working on employee retention and recruitment. ED stated that they are trying such things as employee snack cart, employee dress up theme days, monthly staff recognition, monthly birthday cake and getting a better system in managing time off requests of staff.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 2 800 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on | 2 830 | | 11/13/17 |

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| 2 830 | Continued From page 61<br>individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R19) identified with swallowing difficulties received safe and appropriate assistance from nursing staff when there was an identified concern while feeding a resident. The findings constituted an immediate jeopardy (IJ) situation for R19, with the potential for serious harm, injury or death.<br><br>The immediate jeopardy began on 10/04/17, at 8:12 a.m. when the resident was observed to have on-going issues with coughing while eating. Staff were not following the feeding program established by the speech language pathologist due to dysphagia (difficulty swallowing). The executive director (ED), interim director of nursing (DON), director of clinical services (DOCS), assistant ED-A and ED-B were informed of the immediate jeopardy on 10/04/17, at 4:15 p.m.. The IJ was removed 10/05/2017, at 2:54 p.m., but non-compliance remained at the lower scope and severity of (D) isolated, with potential for more than minimal harm that is not Immediate Jeopardy. | 2 830 | Corrected | |

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In addition, the facilty failed to ensure a behavior plan was in place for 1 of 1 residents (R108) with bullying behaviors which contributed to verbal altercations. Also, the facility failed to comprehensively assess for pain, and provide pain medications timely for 1 of 3 residents (R48) who had complaints of pain. The facility also failed to coordinate hospice services for 2 of 2 residents (R138, R48) reviewed for hospice.

In addition, the facility failed to comprehensively assess safety with smoking for 2 of 4 residents (R21, R20) reviewed for smoking.

Findings include:

Eating

R19's Admission Record undated indicated that he had dementia and dysphagia (difficulty swallowing). R19's annual Minimum Data Set (MDS) dated 09/08/17, indicated he needed extensive assistance of one with eating and had no swallowing disorders. R19's Nutritional Status Care Area Assessment (CAA) dated 09/13/17, indicated he required assistance with feeding at meals and had a need for special diet or altered consistency which might not appeal to resident. The CAA further indicated he received sufficient eating assistance.

A Discharge Summary Note dated 12/02/16, from North Memorial Medical Center, indicated he was hospitalized from 11/30/16 to 12/02/16. The Discharge Summary note identified he had aspiration pneumonia, and x-ray with bilateral infiltrates of the lungs (something that has gotten in to the lungs from the outside. Any abnormal density will show up in the otherwise air filled lungs. Usually the infiltrate will mean pneumonia,

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or some sort of infection with edema/swelling that is in the lung).

R19's Speech Therapist note dated 08/02/17, indicated PT (patient) seen for skilled ST services to address dysphagia and complete final session to receive discharge documentation. Therapist followed up with nursing staff regarding use of printed compensatory swallowing strategies to reduce aspiration risk. A 24-hour log updated for discontinuation of services due to inability to progress due to dementia and inability to follow cues. Nursing staff to implement use of compensatory swallowing strategies and monitor for ongoing signs and symptoms of aspiration.

A 24 Hour Status Report (communication report for nursing staff) dated 08/02/17, indicated: "D/C [discontinue] from ST today continue puree/honey thick liquid diet. Printed strategies at patients table to follow during meals."

The speech therapy instruction sheet directed staff to do the following swallowing strategies:
* Bite sizes should be 1/2 spoonful of puree
* Use spoon to give honey thickened fluids (1/2 spoon size)
*Allow patient to clear mouth completely before giving another bite
* Do not put more food in patient's mouth if he is still chewing
* If he begins coughing, do not give more food until coughing discontinues.

During observation on 10/01/17, at 12:12 p.m. nursing assistant (NA)-B was observed to give R19 a drink of his juice bringing his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She proceeded to have him take three drinks and R19

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started to cough while drinking from the cup. NA-B stopped when he coughed waited from him to stop and then continued to give him a teaspoon full of his potatoes, and then a teaspoon of his pureed roast beef and he coughed again. At 12:19 p.m. NA-B fed him a level teaspoon full of his mashed potatoes and he coughed again. NA-B stated to R19 'It's ok" and gave him a drink of his juice from his cup. At 12:20 p.m. the surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the instructions that were on the window sill of the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive 1/2 teaspoons of food and liquids at a time. NA-B then took the teaspoon at the table and placed in his honey thickened juice and proceeded to feed him 1/2 teaspoons of his food and beverages and his coughing had decreased.

During observation 10/04/17, at 8:12 a.m. HR-A was observed in the first floor dining room assisting R19 with eating. R19 had scrambled eggs, pureed sausage, oatmeal and honey thickened cranberry juice. At the same table directly across from HR-A, sat assistant director of nursing (ADON)-B whom was assisting R134 with eating. HR-A gave R19 a level teaspoon full of pureed sausage and then immediately gave a heaping teaspoonful of his oatmeal, without first waiting for R19 to swallow the spoonful of pureed sausage before immediately giving a heaping spoonful of oatmeal to R19. R19 immediately started to cough, loudly turning his head away from HR-A to the right. HR-A stopped feeding him and rubbed his back and waited for him to stop coughing. HR-A then brought R19's glass of honey thickened cranberry juice just below his

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chin and began spoon feeding R19 three spoonfuls of thickened juice, one after another without first waiting for R19 to swallow each bite. HR-A fed R19 a full teaspoon of thickened juice, not a half teaspoon as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his pureed sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A while she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was not following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scrambled eggs, pureed sausage, and half of his oatmeal and 3/4 of his honey thickened cranberry juice. ADON-B left the same table HR-A was assisting R19 and NA-M then sat down to assist R134 across the same table R19 was sitting at. At approximately 8:25 a.m. SLP-A entered the dining room, and surveyor informed her of the above observation. HR-A was removing R19's clothing protector and SLP-A immediately walked up to the table and instructed HR-A she should have been following her recommendations of bite sizes which is 1/2 spoonful of liquids and food. HR-A then stated that NA-M had just informed her of the SLP instructions and she had stopped feeding R19.

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R19's Nutrition Risk Care Plan dated 09/08/17, indicated he received a pureed diet with honey thickened liquids and needed total assistance to the dining room and reminded of meal times. The care plan did not list specific speech therapy recommendations.

Review of R19's diet card, undated, indicated he needed total assistance to be fed and received honey thickened liquids and a pureed diet. In addition, R19's nursing assistant care sheet, undated, indicated his liquids were honey consistency and he needed total assistance with eating with a note, "see ST [speech therapy] instruction."

During interview on 10/04/17, at 12:25 p.m. licensed practical nurse (LPN)-D stated she was not aware of any feeding recommendations for R19 and stated, "What I don't know I can't tell you!"

During interview on 10/04/17, at 12:42 p.m. SLP-A stated she had written up the instructions with R19's plan of care, and had made these recommendations for R19 on 7/24/17, and trained staff that assisted with feeding him. The SLP indicated she left the feeding instructions at the table where he ate and the instructions would disappear and she would have to make new cards and leave them again at his table. SLP-A stated she also told the interim nurse manager during this time, but she no longer works at the facility. In addition, the SLP-A stated she wrote these recommendations on the 24 hour communication board for all staff to see. The SLP-A further stated R19 will cough while eating and she recommended a swallow evaluation awhile ago, but did not think the facility followed through on her recommendation. She relied

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heavily on the staff to follow through with her recommendations since he was at such high risk for aspiration and it was vital to follow through with SLP's recommendations. The SLP-A stated when she feed R19 1/2 teaspoons of his food and liquids he coughs much less and it reduced his risk of aspiration.

During interview 10/04/17, at 1:01 p.m. ADON-B stated, "I don't know anything about a swallow evaluation" and that she had been working on the floor at the facility for six weeks. This happened "before me and I wasn't aware of the recommendation" and reported she could call his guardian. In addition, ADON-B stated she found out about R19's recommendations last Friday when she overheard a NA instruct another NA how to feed him. ADON-B further stated R19 gets pureed food and you have to give it to him slowly and she was not aware of any portion size but to just feed him slowly.

During interview on 10/4/17, at 3:32 p.m. NA-O stated R19 had coughed a lot while eating, was slow to eat, received thickened liquids and pureed liquids. NA-O stated they use a four ounce glass to assist R19 to drink. If R19 had coughing while using the glass, he would use a spoon for the thickened liquids and give a full teaspoon of fluid. Previously (approximately 3 months ago) there were written directions on the table that directed staff to use a spoon for fluids but these directions were removed from the table. NA-O added staff resumed to feed R19 as did previously, either with a glass or spoon, and monitor his response. NA-O was unaware he needed to give R19 half teaspoon of fluids and not use a glass.

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During interview on 10/04/17, at 3:42 p.m. NA-L stated an educator from the facility instructed her on R19's SLP-A recommendations but she stated, "I told her as soon as you walk away I won't remember what you told me. She didn't say anything and had me sign a paper saying I was educated." NA-L then stated, "I had not fed him since he was on his new diet."

During interview on 10/5/17, at 2:15 p.m. NA-Q stated she received new education and the staff needed to check the meal ticket for any special feeding instruction and directions that referred to the black book would be located on the beverage cart. A nurse needed to be in the dining room prior to staff serving resident and if anyone started coughing or choking they were to alert the nurse. Specific instructions were added to R19's meal ticket.

During interview on 10/5/17, at 2:17 p.m. LPN-F stated she had been educated on the new process regarding residents who have special diet. The ticket on table would have the instructions and if needed would indicate to check the black book which would be located on the beverage cart Nurse needed to be in the dining room prior to serving and supervise staff and assist if there were any issues with coughing or choking. Only trained staff can assist with feeding residents.

Although R19 had a history of aspiration pneumonia, and was at high risk for aspirating, the facility failed to follow the specific SLP-A instructions to prevent aspiration, and had non-trained staff assisting R19 to eat his meal. ADON-B and NA-M were directly across the table while HR-A was feeding R19 incorrectly, and made no attempts to stop or intervene while this

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occurred.

A policy was requested for following SLP recommendations but none was provided.

The immediate jeopardy that began on 10/4/17, at 8:12 a.m. and removed on 10/5/17, at 2:54 p.m. when it was verified by observation, document review, and staff interview of whom could and could not feed residents, that a nurse needed to be in the dining room when residents were eating, where individual resident swallowing guidelines were located in the dining room, and what guidelines to follow to assist R19 to eat. The facility checked other resident with swallowing guidelines to ensure their programs were being followed and updated R19 careplan's along with other residents who were at risk.

R108's facility face sheet, undated, identified R108 had diagnoses of intracranial injury, psychotic disorder, paraplegia disorder, schizoaffective and bipolar disorder. R108's quarterly MDS dated 7/24/17 identified he had intact cognition, disorganized thinking, verbal altercations and physical staff assistance for activities of daily living. The behavior CAA worksheet dated 2/24/17, identified resident displayed delusions and hallucinations which could cause behaviors problems.

During observation on 10/3/17 at 10:12 a.m. R108 was yelling in the entry way of the nursing home at (R71 and R201) stating, "Look at yourself in the mirror and you will see the definition of ugly," R71 yells back. Social Service (SS)-B whom was in the area talks to R71 who is very upset yelling (R108) calls us names all the time and nothing happens, R71 leaves the area.

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R201 who was in the same area, stated, "yeah" in agreement to what R71 was saying. R108 remained in area after the confrontation, looking around, no one talked with R108 about his yelling at R71. At 10:16 a.m., four minutes later, R71 was outside of the administration office yelling at executive director (ED), and assistant executive director (AED)-A, AED-B and director of quality. R71 very upset yelling, he was "tired of him [R108] yelling"' and calling him "an Indian", and (R201) a "Nigger". You have not done anything about this, and I am tired of it. All you tell (R108) to do is calm down, nothing gets done and I am sick of it. You have no idea what I or (R201) have gone through when we get called those's names. "I am sick of it!" The ED, and AED-A tried to calm R71 down. R71 kept telling administration (R108) "bums cigarettes" from (R192) all the time. I have heard him get mad at her, she doesn't like it when (R108) goes off on people, so she gives into him and he gets 3-4 cigarettes a day from her. While R71 was yelling at administration. R108 was sitting in his wheelchair approximately 15 feet away, smiling and grinning with enjoyment while watching R71 yelling at the facility administraiton staff.

R71's admission MDS identified he was cognitively intact, and needed minimal staff assistance with activities of daily living. R201 was just admitted to the facility on 10/2/17. There was no MDS data available as a result of R201 being in her assessment period.

During interview on 10/4/17 6:53 a.m. health unit coordinator (HUC)-B stated R108 was none compliant, and he "instigates riots here", he does this to staff and other residents. He is very demanding to other residents and staff, and wants cigarette. He tells resident's and staff that

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resident until he gets a cigarette. NA-A and NA-C both were unaware of any behavior plan to help deal with R108's behaviors.

During interviews on 10/4/17 at 7:30 a.m LPN-A stated R108 frequently refuses treatments, turning and repositioning along with yelling, screaming, and cursing. He calls other residents and staff, "Niger, Indian and calls the ladies bitches." He is very demeaning and tells staff I pay for you to work, so you have to listen to me. If he wants something he expects you to drop everything and do what he wants. LPN-A indicated she attempted to talk with him softly and make a plan with him, sometimes it works, other times not. He always wants his pain medicaiton sooner than scheduled. His pain medications are due at 3:00 p.m., and at 2:00 p.m. he tries to get them, but you have to stay firm with him and tell him not until 3:00 p.m. Once 3:00 p.m. comes, you need to make sure that you are there with his pain medications, then he seems to build trust with you, as long as you follow through with what you told him. This seems to work, but not all the time. If you break his trust, this will not work. There is no behavior plan the NA or nurses are following for R108, we just do our best.

During interview on 10/4/17 at 7:47 a.m. R201 stated R108 calls me a, "Niger, bitches, hoes, fat ass, and good for nothing person." He calls me everything but a "child of god." I hate being cursed at and making me something that I am not. He hurts my feeling when R108 talks bad to me. He tries to "bum a cigarette", and I tell him "no", then he goes off, yelling at me. R201 stated this was not right that they have to put up with this and he makes me feel that I am not worth anything. When he wants something he can be all sweet until he gets what he wants, and then back

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to himself. Staff talk with him, but nothing changes.

During interview on 10/4/17 at 7:57 a.m. R71 stated he was coming out of the dining room the other day trying to get coffee, and R108 just yelled at him, "Hey, you fucking Indian, why are you not on the reservation." He tells me all the time that I am a, "fucking dirty Indian." I try to ignore him, and tell him "come on dude let it go," but nothing works. I just lost a (significant family member FM-A) on 9/11/17, unexpectedly. He found out about this, and at first he said he was sorry and was good. Then on Tuesday (10/3/17), I was in the dining room watching the television about the shooting in Las Vegas. R108 come up to me and asked for a cigarette, I told him "No". He tells me, I just saw you smoking one, and I know you have one, so I just ignored him. R108 then tells me, "I wonder how you dead [FM-A] is." I turned around and told him why is he like that and left the dining room, then when he was in the hallway entrance yelling, I went off on administration. Nothing changes here, staff do nothing about this, and they tell me they try, but I see nothing, and no changes to this at all.

During interview on 10/4/17, 8:42 a.m. maintenance director (M)-A stated R108's behavior varies, he asks for coffee so I get him a pot of coffee. He calls the kitchen staff the "C word", and has burned his bridges with them. I treat him with respect, talk with him and we get along. If you do little things for him and get his respect he is better, but sometimes not. I can tell by his facial expression his mood. When he has a frown, has a glassy eyed look and staring out into space this is not a good day. SS-A used to roll him cigarettes, not sure what happened to that. R108 smokes a lot, and by the third week of

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the month, his behaviors get really bad because he had ran out of money. When he gets his check, his mood is better, until he spends his money.

During interview on 10/4/17, at 9:12 a.m. HUC-A stated R108's behaviors are bad, he yells at everyone and is demeaning and not nice. He used to have a behavior plan and SS-A rolled cigarettes for him. R108 would come back and get more cigarettes rolled, then sell them to other residents. The more SS-A rolled, the more cigarettes he demanded so that program did not last. As long as they (residents) give him cigarettes, he gets along with them. He tell residents he will pay them back, but he never does, resident avoid him. There is no behavior plan at all.

R108's Mood and Behavior Assessment Care Plan review on 8/8/17, identified bipolar affective disorder, and used Risperdal, Xanax and Vistaril. The interventions included, monitor for side effects, periods of altered perception or awareness, disorganized speech, lethargy, changed in cognitive level, hallucinations and constipation. There are no staff interventions idenfied to assist staff of how to deal with R108's behavior of being demanding, using profanity and name calling of other residents in the facility to help decrease these behaviors.

Review of the Associated Clinic of Psychology (ACP) notes from 3/31/17 to 9/29/17 identify R108 had areas of concern that increased his risk which included: compliance with medical advice, wound care, fluid restrictions, participation in therapies, medication compliance, impulse control, activity level and social isolation. The note identified R108 main focus was cigarettes.

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The ACP recommendations were as identified: staff need to check to make sure he is consistently taking his medicaiton, needs to follow physician recommendations, and compliant with all his cares so R108 can be successful in his recovery; R108 has agreed not to empty his colostomy bag outside; FM-B is helping R108 with the cost of his cigarettes so he has more money to purchase the cigarettes, to help reduce his behaviors. He wants his motorized wheelchair back even though R108 was unsafe using the power chair. R108's power chair has broken parts, and the facility was working on getting parts for this chair, but this is difficult since the chair model has been discontinued. A 3/31/2017 ACP note indicated that using the word "boundaries" is something that R108 knows and responds to, redirecting him by reminding him of the boundaries of his peers and staff may be helpful at times. There is no further mention of using "boundaries." A 7/21/17, and 7/28/17, note identified the writer provided R108 with validation of his feelings and emotional support as effective interventions. The 9/15/17 and 9/29/17 ACP note identified the writer used problem solving, insight oriented therapy, emotional support and reinforcement for positive behaviors as effective interventions.

During interview on 10/4/17 at 9:23 a.m. with ADON-A and SS-A both stated, R108 has lots of behaviors of yelling at staff and resident with very "colorful" words and has called 911 when he wanted to get out of bed and was very sick. He refuses all cares also and is a difficult person. He sees ACP on a regular basis but also refused to see them as well, he does this about once every four visits. He has only verbal behaviors and not physical, cigarettes are his main focus with his behaviors. ACP told us to develop a cigarette

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plan, and roll his cigarettes so his money lasted longer and this would stop him from bothering other residents. This program initially worked, but then he wanted more and more cigarettes. He started to sell them to other residents, then he complained they were not packed right and did not like the taste, so he (R108) stopped this program. This program stopped at the end of June 2017, and we have not implemented any other behavior plan since, we do our best. He uses profanity to get your attention, and if you ask him why, he says that he does this to get their attention. He is a work in progress, we try to figure out what we need to do but we do not have a plan in place for his behaviors and his behaviors have gotten worse since he was placed on 2nd floor. They try to keep him occupied but with the big staff turn over it has been tough to be consistent.

Although ACP has made some recommendations, there was no indication the facility has consistently used these recommendations or had a plan to place to handle or divert R108 behaviors of using profanity, yelling at residents, staff and refusing his cares.

Pain
R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact. The MDS identified diagnoses of anxiety, depression and fracture and received hospice care. The MDS identified R48 was receiving scheduled and as needed pain medication, however, did not receive any non-pharmalogical interventions related to pain. The MDS pain interview indicated R48 had pain occasionally, which made it difficult to sleep at night and limited R48's daily activities. R48 rated her pain a 7 out of 10 at the time of the MDS. R48

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did not have a Pain Care Area Assessment.

During interview on 10/1/17, at 3:53 p.m. R48 stated she had pain from her belly button all the way around to her back, including her shoulders. She rated her pain 9 out of 10, with 10 being the worse pain. R48 stated she hurt like that all the time, and it went away only when she slept, if she could fall asleep. R48 did not display any signs or symptoms of pain during the interview.

R48's physician's orders signed 8/31/17, included the following pain diagnosis: chronic pain, chronically on opiate therapy, degenerative joint disease, migraines, closed fracture of the 4th and 5th metatarsal bones of the right foot and metabolic encephalopathy. The orders included the following medications used to control pain:

- morphine (narcotic for moderate to severe pain) soluble tab 5 milligrams (mg) every 4 hours PRN (as needed), started on 7/11/17.
- morphine soluble tab 5 mg every hour PRN, started on 8/4/17.
- nitroglycerin 0.4 mg dissolve 1 tab under the tongue every 5 minutes up to 3 doses PRN, started 3/6/17.
- gabapentin (nerve pain) 400 mg 2 caps twice daily, started 3/6/17.
- morphine sulfate ER 15 mg 1 tablet every a.m. and 2 tablets in the evening every 12 hours, started 7/29/17.
- MPAP (acetaminophen) 500 mg 2 tabs three times daily, the order did not indicate a start date.

R48's Medication Administration Record (MAR) for October 2017, indicated the following schedule:

- gabapentin 400 mg 2 caps twice daily scheduled for 8:00 a.m. and 8:00 p.m.

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- morphine sulfate ER 15 mg 1 tablet every a.m. and 2 tablets in the evening every 12 hours, scheduled for 9:00 a.m. and 9:00 p.m.
- MPAP (acetaminophen) 500 mg 2 tabs three times daily, scheduled for 8:00 a.m., 12:00 p.m. and 8:00 p.m.

R48's facility medical record lacked a comprehensive pain assessment and a care plan directed towards pain.

On 10/3/17, at 9:37 a.m. R48 was observed seated in her wheelchair in her bedroom. R48 did not display and signs or symptoms of pain, but had a flat affect. R48 stated she had scheduled pain medication for 8:00 a.m. and had not received her medications yet. R48 stated hospice has communicated to the facility it was important to receive the pain medication timely. She stated the floor nurse told her she was running behind on her medication pass this morning. R48 stated she rarely asked for her PRN pain medication as it took staff so long to bring it, she just tries to sleep away the pain. R48 again rated her pain a 9 out of 10.

On 10/3/17, at 10:19 a.m. RN-E administered R48's morning medications by bringing them to her room.

During interview on 10/3/17, at 10:20 a.m. RN-E stated she had a "hectic" morning pre- packaging residents' medications to take on leave from the facility and was just administering R48's morning medication. RN-E stated the medications were scheduled for 9:00 a.m. RN-E stated the staff have an hour before and an hour after the scheduled medication times to administer medication. At 10:22 a.m. RN-A approached RN-E's medication cart. RN-E stated she was just

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administering R48's morning medications, that included pain medications. RN-A then stated, "that's not good." At 10:48 a.m. RN-E stated she administered R48 the following medications after the scheduled time: omeprazole (treatment of gastroesophageal reflux disease) 40 mg, ativan (anti-anxiety) 0.5 mg, morphine sulfate (narcotic) 15 mg, two tablets of Tylenol (pain reliever) 500 mg, two capsules of diltiazem (treat high blood pressure, angina and certain heart rhythm disorders) 180 mg, duloxetine (treat major depressive disorder, ) 60 mg, and two capsules of gabapentin (treat nerve pain) 400 mg.

During interview on 10/3/17, at 11:46 a.m. NA-C stated R48 had never complained of pain to her, but if she did NA-C would notify the nurse. NA-C further stated the nursing assistants did not interact much with R48 as she was independent with most cares.

During follow up interview on 10/3/17, at 2:06 p.m. R48 stated her pain was "pretty bad" right now, and after receiving her pain medications late, it didn't help her pain much. R48 stated she was going to lie down and try to sleep to relieve her pain.

On 10/3/17, at 2:35 p.m. RN-E stated R48 was asked her pain level at least every shift, occasionally she requested PRN pain medication, and usually rated her pain a 7 out of 10 or better. RN-E stated she thought the medications helped her and stated going to chapel was a non-pharmalogical intervention. RN-E stated a comprehensive pain assessment was done on admission, but was not sure if the pain assessments were completed any other time.

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During interview on 10/5/17, at 9:12 a.m. ADON-C stated it was important to receive pain medications timely, because it is hard to get pain under control, and when it gets out of control R48 becomes more anxious increasing the pain.

When interviewed on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain, or had changes to her pain medications within the last few months. ADON-A reviewed R48's chart and stated there should be a comprehensive pain assessment and care plan to help manage R48's pain.

During telephone interview on 10/5/17, at 11:25 a.m. hospice RN-F stated he had communicated to the floor nurse on how giving pain medications timely was very important for R48. RN-F stated it was important not only to control her pain, but for her psychosocial well being as she gets very anxious which increased her pain levels.

HOSPICE

R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had an indwelling urinary catheter. R134's care plan dated 10/17, indicated he had a history of urinary tract infections and had a Foley catheter. R134's Urinary Incontinence Care Area Assessment (CAA) dated 7/27/17, indicated he needed total dependence with toileting and was incontinent of bowel and bladder and staff managed all incontinence cares and used incontinent products. The CAA assessment indicated he had urinary urgency and needed assistance with toileting. The CAA failed

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to indicate he had a catheter.

R134's hospice care plan dated 07/07/17, indicated R134 had alteration in bladder elimination and had an indwelling urinary catheter. Home health/hospice was to assess bladder function, hydration and education on urinary catheter care as needed. In addition the hospice care plan indicated patient, family, caregiver will demonstrate proper catheter care.

On 10/03/17, at 8:22 a.m. R134 was observed in the dining room to have a catheter bag attached below his Broda chair (tilt and space positioning chair).

During interview 10/03/17, at 9:30 a.m. hospice nurse-North Memorial (HN)-A stated R134 had been put on their case load on 07/06/17, and he has had his catheter ever since he was admitted to hospice. In addition, HN-A stated hospice had not changed his catheter, tubing or bag and that was the facility's responsibility.

During interview on 10/05/17, at 8:43 a.m. assistant director of nursing (ADON)-B stated R134 had went to the hospital in July 2017, when he was on third floor and transferred to first floor when he returned from the hospital. ADON-B stated his catheter bag should be changed weekly and the catheter should be changed monthly. ADON-B stated there no orders when he returned from the hospital for catheter care and she was not sure if either had been completed since they had no orders. The ADON-B stated the facility should be responsible for his catheter cares.

During observation 10/05/17, at 8:59 a.m. R134 was observed in bed. His indwelling catheter was

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observed attached to the left side of the bed. The catheter anti-reflux valve and tubing inside was covered in a thick, mucus gray matter.

During interview on 10/05/17, at 9:00 a.m. NA-J stated he did not normally see gray sediment on a catheter. He indicated R134 had been in the hospital and returned to the first floor with the catheter. NA-J stated staff empty the catheter bag each shift.

During interview on 10/05/17, at 9:11 a.m. ADON-B stated the facility should have orders on when to change the catheter, bag and tubing and indicated she was unable to locate orders for R134. ADON-B stated she would assume staff had not changed the catheter, tubing and bag since he returned from the hospital on 07/05/17, (almost two months). ADON-B further stated she noticed the sediment in the catheter and did not know why he had a catheter since he never had one before his hospitalization. ADON-B stated the catheter was placed in the hospital on 6/23/17, and the record did not indicate the reason for the catheter.

During interview on 10/05/17, ADON-B stated she had contacted R134's physician and received orders to remove the catheter since the facility did not have a reason for R134 to have the catheter. ADON-B further indicated she had taken his vital signs and his temperature was 98.2 and had no signs of sepsis.

Although R134 had an indwelling catheter, neither hospice or the nursing home had coordinated his care to identify whom was responsible for care of the catheter for R134.

A Service Agreement By And Between Hospice

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And A Nursing Facility (North Memorial Hospice), dated 05/23/16, indicated: "Combined Plan of Care means a written care plan established, maintained, reviewed, and modified, in collaboration between Hospice and the Nursing Facility that includes (a) an assessment of each patients needs, (b) an identification of Hospice Services, including management of discomfort and symptom relief needed to meet such patient's need and related needs of the Hospice Patient's Family, and (c) details concerning the scope and frequency of such Hospice Services. (d) delineation of accountability of services".

R48's quarterly MDS dated 6/17/17, indicated R48 was cognitively intact. The MDS identified diagnoses of anxiety, depression and received hospice care. The MDS identified R48 was receiving scheduled and as needed pain medication, however, did not receive any non-pharmalogical interventions related to pain. The MDS pain interview indicated R48 had pain occasionally, which made it difficult to sleep at night and limited R48's daily activities. R48 rated her pain a 7 out of 10 at the time of the MDS. R48 did not have a Pain Care Area Assessment.

R48's facility medical record lacked a comprehensive pain assessment and care and a care plan directed towards pain. R48's Palliative care plan dated 8/17, indicated R48 was receiving end of life care related to coronary artery disease and congestive heart failure. The care plan indicated physical symptoms of pain and declining status. Hospice and nursing staff were responsible for disease management. Interventions included: support choices and convey theses choices to attending and consulting physicians and clinical sources as

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needed, liberalize diet according to medical condition, encourage fluids unless contraindicated and per resident comfort level, support resident's decision not to eat or drink, and see pain management care plan. There was no facility pain management care plan.

R48's hospice documentation was kept in a separate binder at the nursing desk, and included hospice changes in the hospice care plan and orders. The most recent Hospice IDG Comprehensive Assessment and Plan of Care Update Report was dated 6/15/17. Hospice start of care was on 3/9/17, and was currently recertified for hospice care from 6/7/17, to 9/4/17. A current problem list included altered comfort. Pain remained a 7, 8, or 9 out of 10 with little change after collaboration with resident and facility nurse, discontinued short acting morphine and increased long acting MS Contin to 30 mg at bedtime.

During interview on 10/5/17, at 10:14 a.m. ADON-A stated she was not aware R48 was having pain and any pain medication changes in the last few months. ADON-A stated the most recent hospice care plan was from July 2017. ADON-A stated the hospice nurse may check in with the floor staff, but the ADON's who managed the care in facility were not getting notified in changes in the hospice care plan to effectively coordinate the needed care. ADON-A stated the communication between the facility and hospice was poor. ADON-A stated she had never been invited to attended a care conference with R48 and her hospice team.

During telephone interview on 10/5/17, at 11:25 a.m. from AserCare Hospice RN-F stated the communications between hospice and the facility

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was going okay. RN-F further stated there has only been one care conference between hospice and the facility since the start of care in March. RN-F stated there were no facility nursing staff present and only the social services assistant (SS)-A and R48's spiritual advisor were present at the care conference. RN-F stated hospice reviewed their resident care plans every two weeks and the company was to fax over the updated forms when completed. RN-F was not sure why the facility's most recent hospice care plan was from July 2017, and there needed to be better coordination of care.

The Hospice Care Services Agreement between the facility and AserCare Hospice set to expire on 11/10/17, indicated: "The facility shall furnish 24 hour room and board care, meeting the personal care and nursing needs of the Hospice Patient in coordination with the Hospice representative and ensure that the level of care provided is what would have been provided by the primary caregiver at home and at the same level of care provided before Hospice care was elected."

R21's quarterly Minimum Data Set (MDS) dated 8/23/17, identified R21 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs).

A Resident Smokers listing dated 9/29/17, was provided upon entrance to the facility on 10/1/17. The listing identified all current smoking residents which included R21.

On 10/1/17, at 3:37 p.m. R21 was seated in her room in her wheelchair. R21 stated she was waiting to go outside to smoke adding, "I smoke on my own," after staff help her get outside.

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| 2 830 | Continued From page 86<br><br>During subsequent observation on 10/2/17, at 12:50 p.m. R21 was outside on the patio by the main entrance with other residents, including R96, smoking with a lit cigarette in her right hand. No staff were present outside on the patio with R21, and she had no visible smoking apron on. R21 was able to bring the cigarette to her mouth and ash without dropping any ash(es) on herself or her clothing. R21 stated, "People [staff] always take me," outside to smoke adding they light the cigarettes for her. At 12:58 p.m. activities aide (AA)-A approached R21 while outside smoking and conversed with her. AA-A invited R21 to bingo stating he would, "come back out here when you're done smoking," and bring her back inside. Afterwards, R21 was approached by another resident, R134, who asked her for her lit cigarette. R21 handed her lit cigarette to R134 who used it to light his own cigarette. At 1:02 p.m. registered nurse (RN)-A brought another resident outside to smoke and observed R21 smoking. RN-A asked R21 aloud, "who gave you a cigarette?" R21 responded to her, "I smoked it already," after throwing it on the ground next to her wheelchair.<br><br>R21's medical record was reviewed. A completed Smoking Safety Data Collection and Assessment dated 10/2/17, identified R21 was unable to communicate understanding of the smoking standards and procedures, did not demonstrate appropriate use of an ashtray, nor ability to appropriately extinguish a cigarette. R21 was identified to be a "dependent smoker," and directed to refer to the facility smoking policy for supervision requirements. The assessment was signed on 10/2/17, by assistant director of nursing (ADON)-A (the same day the surveyor observed R21 smoking outside without staff supervision). | 2 830 | | |

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R21's progress note dated 10/2/17, at 1:25 p.m. identified an entry of, "[R21] was outside smoking. Smoking assessment completed. Resident is deemed a dependent smoker. Smoking materials removed from resident & [and] put in med room."

When interviewed on 10/3/17, at 9:28 a.m. nursing assistant (NA)-F stated R21 used to smoke but, "does not anymore." NA-F stated R21 was not going outside to smoke to her knowledge.

During interview on 10/3/17, at 9:51 a.m. ADON-A stated R21 was not a smoker until yesterday when staff found cigarettes in her room. ADON-A stated she was directed to complete a smoking assessment yesterday because R21 went outside and was smoking. ADON-A stated she was not sure why R21 had been included on the list of smokers presented upon entrance, however, added it was important to assess safety with smoking for residents to prevent injury or burns.

R96's annual MDS dated 6/21/17, identified R96 had intact cognition. When interviewed on 10/3/17, at 3:04 p.m. R96 stated staff bring R21 outside to smoke, and had done so several times in the past.

When interviewed on 10/3/17, at 3:06 p.m. assistant executive director (AED)-B stated the Resident Smokers listing provided on entrance was created by asking the nurse managers and social services staff on each floor who is currently smoking. AED-B stated the listing was current upon the survey team entrance as, "that's who they [staff] gave me," as current smokers.

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| 2 830 | Continued From page 88<br><br>R20's Admission Record, dated 10/3/17, identified resident had multiple mental health diagnoses, in addition to heart failure, hypertension, and diabetes.<br><br>R20's quarterly MDS dated 7/9/17, identified moderate cognitive impairment with fluctuating episodes of attentiveness and disorganized thinking, as well as moderate symptoms of depression. R20 was noted to receive extensive assistance with transfers and supervision for locomotion on the unit. The MDS failed to identify R20's tobacco use status.<br><br>During interview on 1/03/17, at 9:49 a.m. the hospice nurse (HN)-A identified R20 "Loved to smoke." HN-A stated R20 experienced a fall while outside smoking independently during the night shift, and shortly thereafter was unable to go out unsupervised.<br><br>Upon review of nursing progress notes of 8/22/17, at 3:50 a.m. it was noted R20 was found on the floor in front of the facility at 2:45 a.m.. R20 was noted to have a cut on bridge of the nose and was sent to the emergency room for evaluation and treatment, returning to the facility at 5:15 a.m.. A subsequent note of 8/23/17, at 5:30 a.m. identified R20 was non-compliant with supervised smoking and a 15 minute check was initiated. A review of progress notes did not identify any additional information regarding 15 minutes checks or smoking activities. A progress note of 9/1/17. identified R20 had been noted to be in the parking lot on two occasions. The note further stated R20 had been advised if she continued to go outside without supervision to smoke, a wanderguard would be placed due to her lack of physical capacity to get back into the facility and potential for injury with traffic. An order | 2 830 | | |

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was obtained on 9/1/17, for use of a wanderguard and this was placed on R20.

A review of R20's care plan noted R20 was at risk for injury related to smoking. The care plan noted a smoking assessment had been completed on 10/26/16, and identified R20 met the criteria to smoke independently. A subsequent smoking assessment, dated 2/13/17, identified R20 was felt to be a dependent smoker (requiring supervision) due to cigarette burn holes noted in clothing and would require supervision with smoking. The care plan did not reflect any change in status, indicating a need for supervision. The care plan review and signatures were in place for 5/11/17 and 8/11/17, with no changes made to care plan interventions. The care plan did not reflect recent placement of wanderguard for safety, effective 9/1/17.

During interview on 10/3/17, at 2:37 p.m. the health unit coordinator (HUC)-A stated R20 did require supervision with smoking for the last two weeks prior to her death on 9/23/17, however, was unsure of the rationale as this was under the direction of upper management. R20's cigarettes were kept in the medication room once supervision was required.

During interview on 10/03/2017, at 2:53 p.m. NA-U stated R20 had been independent with smoking but was aware this had changed approximately two to three months ago, although was unaware of the reason.

During interview on 10/3/17, at 2:57 p.m. NA-T stated R20 had been independent with smoking until the last month, when she required supervised smoking due to weakened health.

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| 2 830 | Continued From page 90<br>During interview on 10/5/17, at 10:57 a.m. the director of social services (DSS) stated R20's mood state was impacted upon availability of cigarettes, stating that when her supply was gone R20 would pick up cigarette butts off of the ground. The DSS stated staff members were aware of this behavior and this contributed to placement of the wanderguard. The DSS stated he had not observed R20 ashing on herself, posing a risk for burns.<br><br>During interview on 10/5/17, at 11:14 a.m. with ADON-A and ADON-D. ADON-A stated R20 had previously been independent with smoking, however, as her health declined R20 was unable to get in and out of facility easily and a wanderguard was placed at that time.<br><br>ADON-D stated the use of the wanderguard alarm did not affect R20's ability to smoke, but alerted staff of resident attempts to exit without supervision. A review of the care plan was completed by ADON-D and noted R20 was noted to be an independent smoker, and a revision had not been make following the assessment of 2/13/17.<br><br>ADON-A stated was unaware R20 was to have been a dependent smoker, further stating if an assessment had any indication for dependent smoking the care plan should have been updated. ADON-A stated due to staff turnover, a comprehensive care plan review had not been done.<br><br>A facility MN (Minnesota) Smoking Policy dated 4/2017, identified the facility allows smoking for residents, "...who have been assessed to be independent smokers or have a safe smoking plan in place." Further, the policy directed staff | 2 830 | | |

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| 2 830 | Continued From page 91 to evaluate smoking abilities upon admission, quarterly and with any significant change in condition.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate and monitor responsible staff, to assure residents' are receiving the supervision and care based on the facility's comprehensive assessment of each resident's needs.<br><br>Also - The director of nursing and/or designee could educate licensed staff how to comprehensively assess and care plan for residents who wish to smoke, to do so safely.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 830 | | |
| 2 895 | MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion<br><br>Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.<br><br>This MN Requirement is not met as evidenced | 2 895 | | 11/13/17 |

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| 2 895 | Continued From page 92<br>by:<br>Based on observation, interview and document review, the facility failed to consistently provide range of motion (ROM) services for 1 of 2 residents (R121) reviewed whom had a limited range of motion and restorative nursing.<br><br>Findings include:<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent upon and required the physical assistance of two staff for bed mobility, eating, dressing, toileting and personal hygiene. A facility document, Therapy Recommendations for Restorative Program for R121, dated 4/6/17, indicated "Passive and/or Active Range of Motion." R121's Restorative Program History report, printed 10/4/17, indicated R121's passive ROM program goal to be: Resident will maintain current range of motion with assistance of doing PROM to bilateral extremities twice a day for 15 reps each time. The program directed: 1. Explain procedure; 2. Perform PROM to bilateral lower extremities and; Report to nurse any complaints of pain, refusals. R121's mobility care plan, dated 4/17, identified contractures and muscle stiffness as a target problem.<br><br>During interview on 10/2/17 at 6:22 p.m., family member (FM)-C stated she had "a concern" about the ROM programs getting completed. FM-C stated when she visits, she completed the ROM for R121, and stated of late had been rolling towels and places rolled up hand towels in R121's hand to keep them from rolling up and getting tight. FM-C stated she "questioned" if (R121's) | 2 895 | Corrected | |

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ROM program was getting done. FM-C stated R121 was to get ROM twice daily, but stated "I'm not sure staff are doing that."

During observation on 10/3/17 at 8:18 a.m., R121 was lying in his bed in his room, facing the window, a pillow under his left side. R121's arms were at his side, elbows folded and forearms at 45 degree angle from his elbow, and situated upon his stomach. R121 wore heel boots, bilaterally, on his feet. During continuous observation from 8:18 am to 11:32 a.m., R121 remained lying on his bed in his room. At 9:29 a.m., nursing assistant (NA)-D and registered nurse (RN)-B repositioned R121. At 11:32 a.m., RN-B, NA-D and NA-B assisted with R121 with a dressing change and repositioning. At 1:58 p.m., R121 was again repositioned by NA-B and NA-D. R121 was not offered nor was provided any range of motion during any of the visits by nursing staff during these time frames.

During interview on 10/3/17 at 2:06 p.m. NA-D stated she assisted R121 only to reposition and did not do any kind of ROM exercises. NA-D stated she "did not think" R121 has any range of motion or exercise program.

When interviewed on 10/3/17 at 4:38 p.m., RN-B stated R121 did not have any orders for restorative nursing. RN-B stated if there was a program from therapy, "licensed staff would be doing that." RN-B stated there were no orders in the treatment record for range of motion for R121. RN-B stated, however, R121 could benefit from a ROM program, so (R121) could keep his arms and hands "more limber."

During observation of the morning routine on 10/4/17 at 9:42 a.m., NA-A and NA-C assisted

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R121 with morning cares, including repositioning and oral cares. There was no provision or offer to complete range of motion for R121 during his morning routine.

When interviewed on 10/4/17 at 9:48 a.m., NA-C stated R121 did not have a range of motion program, and has not assisted him with that. NA-C stated often therapy often worked with resident in their rooms, but has not seen anyone work with R121 in his room. NA-C stated she did not perform ROM for R121.

During an interview on 10/4/17 at 9:59 a.m., NA-A stated she did not think R121 had any range of motion program, and if he did, we would have had "someone from therapy" show us what to do. NA-A stated she did not help R121 with any exercise or range of motion.

A review of the ROM (Range of Motion) detail report from 7/8/17 to 10/4/17 indicated the following number of times ROM was provided R121; number of refusals; and number of times ill:
July 20x (times) ROM; 4x refusals; and 2x ill
August 34x ROM; 1x refusal; and 2x ill
September 15x ROM; 3x refusals; 1x ill
October (through 10/4) 2x ROM; 0x refusals; 0x ill

During interview on 10/4/17 at 7:43 a.m., the director of therapy (DT) stated R121 has been on therapy case load a number of times. Upon his return from hospitalization in early April, a restorative program was recommended for R121. The DT stated she was at R121's care conference about two months ago and recalled a discussion that ROM that was being completed for R121. She was unable identify how his ROM

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program was being monitored for compliance. The DT stated R121 had muscle contractures and would be a candidate for passive range of motion exercises.

When interviewed on 10/4/17 at 8:16 a.m., physical therapist (PT)-A stated R121 was evaluated last April, following hospitalization. At that time R121 was unable to actively participate in range of motion and his condition has remained unchanged. PT-A stated R121 definitely "would benefit" from ROM and described the plan to include PROM to legs, knees, ankles, bilaterally, and usually 10 reps (repetitions) each, and the exercises be done twice daily.

When interviewed on 10/4/17 at 8:43 a.m. the assistant director of nursing (ADON)-C stated R121 had a restorative program and futher the aides should be completing that task, during cares or when repositioning. The ADON questioned how R121 could be 'refusing' the program because of his current disposition and stated the ROM program was to be completed twice daily, 15 reps each time. ADON-C also stated even though this was not "spelled out" in the care plan, the instructions for restorative program in care tracker was part of the care plan, and she "expected" R121 was to receive range of motion services.

A facilty policy, Contracture Prevention, dated July 2015, indicated as it purpose "To maintain or improve joint mobility to assist resident in maintaining or achieving independent function, or preventing or reducing contracture or deformity. The Policy included providing PROM (passive range of motion) as an intervention to achieve the goal.

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| 2 895 | Continued From page 96<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate the responsible staff in the provision of resident range of motion programs, according to their assessed needs, to prevent resident contraction and/or maintain current level of physical ability. The DON or designee could conduct of range of motion programs for residents to ensure the services are implemented consistently.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 895 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by: | 2 900 | | 11/13/17 |

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| 2 900 | Continued From page 97<br>Based on observation, interview and document review, the facility failed to provide timely repositioning for 2 of 4 residents (R121, R134) whom had or were identified at risk for pressure ulcer development. In addition the facilty did not provide a comprehensive assessment for 1 of 2 residents (R6) in the sample with a stage three pressure ulcer.<br><br>Findings include:<br><br>TURNING REPOSITIONING<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent and required the physical assistance of two staff for bed mobility, and toileting. The MDS indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue). The care area assessment (CAA) worksheet for pressure ulcers, dated 8/21/17, also identified R121's total dependence upon staff for bed mobility. The CAA indicated R121 was incontinent of bowel and bladder, was unable to communicate needs and did not speak,further staff anticipated R121's needs. The CAA also indicated R121 had a stage 4 area to coccyx, and was seen by a wound doctor weekly.<br><br>During observation of R121's dressing change on 10/2/17, at 12:34 p.m., R121's wound was observed. R121's wound was open, on the coccyx area, and measured approximately 4 centimeters (cm) by 2.5 cm with depth of 1.25 cm. The wound bed was dark pink in color. The surrounding skin was intact, normal in color, and free of maceration or swelling. The wound was | 2 900 | Corrected | |

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without odor, and had minimal drainage.

During continuous observation on 10/3/17, from 11:32 a.m. to 1:58 p.m. (2 hours and 26 minutes), R121's positioning in bed which remained unchanged. At 1:58 p.m., nursing assistants (NA)-D and NA-B entered R121's room, closed the door behind them, and announced to R121 they were going to "check you" and "reposition you." Working on each side of R121's bed, NA-D and NA-B raised the bed to a working height, and began their cares, talking with R12. R121's brief was checked and was not wet. NA-B removed the pillow from under R121's left side, and NA-D took out the pillow between his legs. Together NA-B and NA-D pulled R121 up in bed, then refitted the pillows between his legs, and then placed R121 slightly facing the window, with a pillow under R121 right back side. The pillow between R121 legs was replaced, and legs adjusted, then R121 was covered with the bed sheet. Before NA-B and NA-D exited the room, they removed gloves and washed their hands.

During an interview on 10/3/17, at 2:06 p.m., nursing assistant (NA)-D stated the last time R121 was "done" (repositioned) was at 11:30, and now it was two o'clock. NA-D stated we got busy, and that (R121) should be checked and turned every two hours. NA-D stated "it was late."

The "Skin Integrity Assessment: Prevention and Treatment Care Plan" for R121, dated 4/17, identified R 121's pressure ulcer to coccyx, and directed a turn and reposition program with a frequency of "Q2" (every) two hours. The care plan also directed staff to monitor wound weekly and PRN (as needed).

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| 2 900 | Continued From page 99<br>Review of Wound Care Specialist Evaluations:<br>--Initial Evaluation, dated 4/26/17, indicated R121 has wound on coccyx. Wound size (L x W X D) (length, by width by height): 2 x 0.5 x no measurable cm (centimeters). 100% granulation tissue. At request provider, R121 presents with a stage 3 pressure ulcer wound Coccyx of a least 1 day duration. There is no exudate (drainage). There is no indication of pain associated with this condition. Wound size 1.0 Under assessment and Plan of Care Recommendations: stage pressure ulcer wound -coccyx-initial evaluation. Discontinue house barrier cream twice daily; add skin Prep once daily, foam, once daily; group 2 mattress (pressure reducing), vitamin C 500 mg twice daily, zinc sulphate 220 mg once tail for 14 days, off load wound, reposition per facility protocol. Factors complicating wound healing: anemia.<br><br>--evaluation dated 5/24/17: Pressure wound,;stage 4; duration greater than 27 days; wound size 6.5 cm x 7 x 0.3 cm; light ser-sanguinous exudate; 15% thick adherent devitalized necrotic (dead, scar) tissue; 40% granulation (new growth) tissue; 45% skin; wound progress: deteriorated. Assessment and Plan of Care recommendations: surgical excisional debridement; continue skin prep once daily; foam once daily; Santyl once daily.<br><br>--evaluation dated 6/14/17: Pressure wound stage 4; duration greater than 26 days; wound size: 6.2 x 3 x 0.3 cm; light sero-sanguinous exudate; 100% thick adherent devitalized necrotic tissue; wound progress: deteriorated. Assessment and Plan of care recommendations: surgical excisional debridement; continue skin prep, foam and Santyl once daily. | 2 900 | | |

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| 2 900 | Continued From page 100<br><br>--evaluation dated 6/21/17: pressure wound, stage 4, greater than 53 days; wound size 4.5 x 3 x 2.3 cm; light sero sanguinous exudate; 75% thick adherent devitalized necrotic tissue; 25% granulation tissue; wound progress improved. Assessment and Plan of Care Recommendations: surgical excisional debridement. Discontinue skin prep once daily; foam once daily; Santyl once daily; add negative pressure three time per week, skin prep to peri wound are.. three time per week.<br><br>--evaluation 6/28/17: pressure wound stage 4, greater than 50 days in duration; sound size 4 x 4 x 1.8 cm; peri wound (area around wound): odor surrounding DTI (deep tissue injury) (purple/Maroon) maceration; moderate Sero -sanguinous exudate; wound progress deteriorated. Assessment and Plan of Care Recommendations: surgical excisional debridement; continue negative pressure three times per week; skin prep to periwound area three times per week.<br><br>--evaluation 7/5/17: pressure wound stage 4, greater than 66 days in duration; wound size: 5.2 x 4.8 x 2.4 cm; periwound radius odor; undermining (tunneling under skin) 4 cm at 3 o'clock (position on wound); moderate Sero-sanguinous exudate; 60% thick adherent devitalized necrotic tissue; 40% granulation tissue; wound progress improved. Assessment and Plan of Care Recommendations: surgical excisional debridement; negative pressure three times per week; skin prep to periwound area, three times per week. Prealbumin recommended on 7/5/17<br><br>--evaluation 8/9/17: pressure wound stage 4, greater than 99 days; wound size 4.4 x 4 x 3.8 | 2 900 | | |

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cm; light Sero sanguinous exudate; 100% granulation tissue; wound progress improved. Assessment and Plan of Care Recommendations: improved as evidences by decreased surface area, increased granulation , continue: protective dressing, twice daily, wet to moist, twice daily.

Review of recent Wound Assessment Skin Grid, for R121 indicated the following:
--9/27/16 stage 4 pressure ulcer (PU) measuring 4.1 cm (centimeters) in length, x (by) 2.8 cm in width, x 1.3 cm in depth; no drainage from the wound; red in color and had tunneling (open areas under the wound) at 12 o'clock (location on the wound); no blood noted, area is painful to touch.
--9/20/17: stage 4 PU; 4 x 3.2 x 2.0 cm, bloody drainage, necrotic (dead tissue) slough and mild odor; undermining at 12 o ' clock; debrided by doctor, d/t (due to) necrotic tissues, wound deeper and mild odor; air mattress frequently at wrong setting, education done with staff by writer.
--9/11/17..stage 4 PU; 3.6 x 3.0 x 1.0 cm; serosanguineous drainage, red in color, no odor, tunneling 3 to 8 o'clock.
---9/6/17 stage 4 PU; 3.8 x 3.0 x 1.3 cm; sero-sanguineous drainage, red in color, no odor, and tunneling 3 to 8 o ' clock.
--8/30/17 No weekly skin grid assessment found
---8/23/17 No skin grid assessment found
---8/17/17 stage 4 PU, 3.8 x 3.6 x 2.5; sero sanguineous pink drainage; no odor and tunneling/undermining 3.8 cm depth at 12 o'clock
---8/9/17 no weekly skin grid assessment
---8/2/17 no weekly skin grid assessment
---7/26/16 no weekly skin grid assessment
---7/19/17 no weekly skin grid assessment
---7/12/17 no stage PU listed; 5.0 x 4.0 x 3.0; serosanguinous drainage with necrotic/slough

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| 2 900 | Continued From page 102<br>tissue 40%; no odor; tunnel/undermining at 2 o'clock with depth 4.5 cm.<br>---7/5/17 no stage PU listed; 5.2 x 4.8 x 2.5 cm; serosanguinous drainage; necrotic/slough 60%; mild odor; tunneling/undermining at 4 o ' clock with depth of 4 cm.<br>---6/28/17 no stage PU listed; 4.0 x 4.0 x 1.8 cm; serosanguinous drainage; red in color; foul odor; no undermining/tunneling identified<br>---6/21/17 no stage listed; 4.5 x 3.0 x 2.3 cm; serosanguinous drainage; no odor; no tunneling/undermining identified<br>---6/14/17 no stage PU listed; 6.2 x 3.0 x 0.3; serosanguinous drainage; 100% necrotic tissue; no odor; no tunneling/undermining identified<br>---5/31/17 no stage PU listed; 6.5 x 2.5 x 1.2 cm; serosanguinous drainage; necrotic tissue; no odor, no tunneling/undermining identified<br>--5/24//17 no PU stage listed; 6.5 x 7 x 3.0 cm; serosanguinous drainage; necrotic tissue; no odor; no undermining/tunneling<br>---5/17/17 no PU stage listed; 6.0 x 2.3 x 0.1; serosanguinous drainage; necrotic tissue present; no odor; no undermining or tunneling<br>---5/10/17 no PU stage listed; 2.1 x 0.6 x 0.1; serosanguinous drainage; pink tissue noted; no odor; no tunneling or undermining<br>---5/3/17 no PU stage listed; 2.3 x 0.6 x 0.1; no drainage; pink tissue noted; no odor; no tunneling or undermining<br>---4/26/17 no PU stage listed; 2.0 x 0.5 x 0 cm; no depth, no drainage, no color; no odor; no undermining/tunneling<br>---4/19/17 no PU stage listed; 3.5 x 4 cm no depth; no color; no drainage; no odor; no tunneling /undermining<br>---4/12/17 (onset); indicated no present upon admission; site is coccyx; 0.2 x 0.2 and 0.1 cm; no drainage, no color, no odor; no undermining | 2 900 | | |

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During interview on 10/2/17, at 6:14 p.m., family member (FM)-A stated she was aware of R121's "bed sore" and stated she had concerns that he was not getting repositioned off his bottom timely. FM-C stated there were frequently times when she was at the facility when R121 was left "for three hours" before he was turned. FM-C stated she told the aides "he's supposed to be (repositioned) every two hours." FM-C stated due to the wound, staff need to make sure [R121] stays as dry as possible." FM-C stated she did not think R121's repositioning always got done right. FM-C stated there was an issue with "staffing," no consistency, with so many new people always working. FM-C stated she had told staff they have to treat (R121) "like you'd treat family."

When interviewed on 10/3/17, at 4:30 p.m., registered nurse (RN)-B stated it was his expectation that residents be turned "timely" so that the wound could be taken care of and not break down more. RN-B stated R121 had a open, stage 4 pressure ulcer, and also it was "not acceptable" that R121 was not turned as he was supposed to be. RN-B stated he thought some of the aides needed more training and needed to be more aware of the residents' care needs.

During interview on 10/4/17, at 11:22 a.m., medical doctor (MD)-B, a provider for R121, stated the pressure ulcer was at stage 4, and was not deteriorating, but the wound was stable. MD-B stated "98%" of R121's wound improvement and success would be due to nursing, and the aides need to have him "turned and repositioned timely." MD-B stated the current orders included twice daily cleansing of the wound, and wet to moist dressing with Dakins solution, which is an great antiseptic, and crushed

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Flagyl right into the wound.

When interviewed on 10/4/17, at 8:52 a.m., the assistant director of nursing (ADON)-C stated R121 had a current stage 4 pressure ulcer, and also skin and wound assessments were to be completed by licensed staff at least weekly, and would expect the assessments be documented at least weekly. ADON-C stated she exoected R121 to be turned and repositioned every 2 hours as care planned.

R134's significant change Minimum Data Set (MDS) dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with bed mobility, transfers and toileting. The MDS further indicated he was at risk for pressure ulcers and had no pressure ulcers. R134's Care Area Assessment (CAA) dated 07/27/17, indicated he was dependent on staff for activities of daily living (ADLs) and is repositioned per staff and transfers with assist of two and mechanical lift. The CAA futher indicated he used a wheelchair with a cushioned seat and was incontinent of bowel and had an urinary catheter. In addition, the CAA indicated he was at risk for pressure and required staff assistance to move sufficiently to relieve pressure over any one site and required regular schedule of turning.

R134's Skin Integrity Assessment: Prevention And nutrition, friction and shear. The care plan further indicated he was to be repositioned every two hours and to provideTreatment Plan Of Care dated 10/03/17, indicated he required frequent turning, protect heels and manage moisture, a pressure relief surface. In addition, the care plan indicated he was always incontinent of bowel movement (BM) will have decreased episodes of incontinence by a established elimination

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schedule and will be cooperative with assisted toileting. 32 minutes) R134 was observed to be sitting in his Broda chair (tilt and recline positioning chair), without being repositioned/toileted or check and change. At 8:35 a.m. R134 was observed across from the nurses station on the first floor, at 9:00 a.m. R134 was moved across from the nurse's station in the hall, at 9:12 a.m. R134 was asleep in the Broda chair, at 9:30 a.m. registered nurse (RN)-K/ hospice nurse moved R134 from the hall to the dinning room. At 10:02 a.m. RN-K moved R134 back into the hall across from the nurse's station. At 10:22 a.m. R134 was asleep in the hall in his Broda chair. At 10:42 a.m. R134 was still in hallway in chair asleep. At 11:00 a.m.

During continuous observation 10/03/17, from 8:35 a.m. to 11:07 a.m. (2 hours and he was still asleep. At 11:07 a.m. surveyor informed nursing assistant (NA)-M and NA-J of findings.

During interview 10/03/17, at 11:01 a.m. NA-N stated that he had repositioned and checked him for incontinence right after breakfast around 8:30 a.m..

During interview 10/03/17, at 11:12 a.m. NA-M stated she had assisted NA-N right after breakfast with repositioning R134. She indicated did not have a chance to reposition him again because they do not have enough staff and that he needed assist of two so she could not reposition him timely.

During observation 10/03/17, at 11:30 a.m. (almost 3 hours without repositioning) NA-J and NA-N were observed to reposition and check R134. R134 was continent of bowel and had a catheter for urine. In addition, R134's skin was

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intact with no open areas or redness of the skin.

A Procedure Turning and Positioning, effective July 2015 indicated: "The center provides assistance with turning and positioning. Residents will be turned and positioned according to their co-morbidities and individual abilities. The center strives to avoid musculoskeletal injury and fatigue and reduce the risk of injury of residents with the use of positioning techniques. The center strives to prevent pressure ulcers with turning and repositioning. Turning and repositiong may prevent pooling of lung secretions and improve circulation."

Although R134 was assessed to be at risk for pressure ulcers and was care planned to be turned and repositioned every two hours, R134 went almost three hours without being repositioned to help prevent development of pressure ulcers.

A facility policy, Pressure Ulcer Prevention/Treatment, dated July 2015, indicated all residents would be assessed upon admission and at regular intervals. Further, the policy identified interventions to manage pressure, including the use of turning and repositioning, and also directed to review and revise the skin integrity assessment to reflect interventions to heal pressure ulcers and stabilize, reduce or remove underlying risk factors.

LACK OF ASSESSMENT:

R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs), had unhealed pressure ulcers and remained at risk for further pressure ulcer

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development. Further, the MDS identified R6 had rejection of care(s) on a regular basis, "but less than daily." R6's Diagnosis Report dated 7/25/16, identified R6 had diabetes, peripheral vascular disease (PVD), schizophrenia, personality disorder, and bipolar disorder.

R6's progress note(s) dated 9/1/17 to 10/3/17, identified R6 to have numerous, documented episodes of wound and pressure ulcer dressing change refusals, including an entry on 9/13/17, when staff removed R6's sock and, "[approximately] 30 maggots fell on to the floor," R6 was further documented to, "would not have writer do rest of tx [treatment]."

R6's Braden Risk Assessment Scale dated 8/14/17, identified R6 to be at moderate risk of pressure ulcer development and skin breakdown. R6's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 8/7/17, identified R6 was at moderate risk of pressure ulcer development and had a history of past pressure ulcers. The care plan listed several interventions including keeping his skin clean and moist, encouraging him to reposition every two hours and, "Complete Push [Pressure Ulcer Scale for Healing] Tool Weekly."

During observation on 10/2/17, at 1:10 p.m. R6 was laying in bed in his room. The bed had an air mattress in place, and R6 had a visible urinary catheter drainage bag sitting on the floor. R6 stated he had pain due to a, "severe wound on my tail bone," which he obtained, "from sitting in the wheelchair." Further, R6 stated staff come in and try to reposition, however, added he doesn't want them to.

During interview on 10/2/17, at 1:42 p.m.

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registered nurse (RN)-A stated R6 had several current pressure ulcers including a stage 3 or 4 (ulcer extends into the dermis exposing fatty subcutaneous tissue) on his coccyx.

On 10/3/17, at 2:36 p.m. RN-A was going to complete a dressing change to R6's pressure ulcer. R6 declined to have the surveyor observe the wound stating, "He'd rather not."

R6's Skin Grid - Pressure/Venous Insufficiency Ulcer/Other tracking chart dated 9/26/17, identified R6 had a stage III pressure ulcer on his coccyx with an, "Initial Identification," recorded on 9/16/17, measuring 1.8 cm (centimeters) by 0.5 cm by 3.0 cm in size. The ulcer had no recorded tunneling or undermining identified, and no drainage or odor present. The tracking chart identified R6 refused to have his ulcer assessed on 9/20/17. The next recorded entry on 9/26/17, identified the ulcer remained a stage III measuring 2 cm by 1 cm by 3 cm in size, however, now had serosanguineous drainage (thin and watery, often pink in color) and mild odor with 5.4 cm of tunneling.

R6's medical record was reviewed and lacked any completed PUSH tools as directed by R6's care plan, nor a comprehensive reassessment of R6's skin risk factors, including his history of refusals, and subsequent interventions to address R6's coccyx pressure ulcer after it worsened on 9/26/17.

When interviewed on 10/3/17, at 1:25 p.m. RN-A stated R6 does not allow his pressure ulcer dressings to be changed often adding the pressure ulcer(s) were primarily tracked using the skin grid tracking charts on a weekly basis. RN-A stated R6's coccyx pressure ulcer was, "getting

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worse," and staff were trying to have him see a wound physician to help develop a plan to address it. RN-A stated R6 had not allowed the coccyx ulcer to be observed again since 9/26/17. RN-A stated she was unsure what a comprehensive skin assessment would consist of, and added she was unsure where to locate one, if one had been completed, in the medical record. Further, RN-A stated was unaware who was completing the PUSH tool(s) identified on R6's care plan, nor where they were located in the medical record.

During subsequent interview on 10/3/17, at 2:33 p.m. RN-A stated the PUSH tool was used to help determine if the wound was, "getting bigger, getting worse or stalled." RN-A stated the PUSH tools were not being completed, "at this moment," but would be completed on a weekly basis going forward.

When interviewed on 10/4/17, at 1:37 p.m. the interim director of nursing (DON) stated a comprehensive skin assessment would include completion of the PUSH tool to help determine if the current treatment was effective or if something different needed to be done.

An undated, uncompleted Pressure Ulcer Scale for Healing (PUSH) tool identified directions to observe and measure each ulcer and total the resulted scores adding, "A comparison of total scores measured over time provides an indication of the improvement or deterioration in pressure ulcer healing." The tool listed a, "Pressure Ulcer Healing Graph," section which ranged in number(s) from 17 (worst possible) to 0 (healed) and allowed staff to identify the pressure ulcer progress.

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SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could review/revise policies for pressure ulcer assessment, and implementation of pressure ulcer interventions and educate the responsible staff on these policies. The DON or designee could conduct audits to ensure the repositioning needs of each resident with and/or at risk for pressure ulcer development, according to their individual comprehensive assessment are consistently met.

TIME PERIOD FOR CORRECTION: seven (7) days.

| 2 910 | MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence | 2 910 | | 11/13/17 |
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Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:
A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and
B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This MN Requirement is not met as evidenced by:

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| 2 910 | Continued From page 111<br><br>Based on observation, interview and document review, the facility failed to provide medical justification for use of an indwelling catheter for 2 of 3 residents (R48, R134) reviewed for indwelling catheter. In addition, the facility failed to comprehensively assess the bladder function and put into place interventions to minimize incontinence for 2 of 4 residents (R55, R2) reviewed for urinary incontinence.<br><br>Findings include:<br><br>CATHETER<br><br>R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and had an indwelling urinary catheter. Diagnoses included anxiety, depression and a fracture. The MDS did not indicate R48 had diagnoses of neurogenic bladder or obstructive uropathy.<br><br>On 10/3/17, at 9:37 a.m. R48 was observed in her room to have a catheter attached to her right leg draining yellow urine. R48 stated hospice placed a Foley catheter as R48 was having to urinate every two hours and was not getting any sleep. R48 did not display any signs or symptoms of pain.<br><br>R48's Bladder Data Collection and Assessment dated 8/15/16, and reviewed 1/10/17, indicated R48 was continent of urine. The assessment did not identify any form of incontinence or nocturia.<br><br>R48's nursing progress note dated 5/1/17, at 9:00 p.m. indicated R48's hospice nurse inserted a Foley catheter and was to be maintained by hospice. The progress note did not indicate why R48 had a Foley catheter placed and lacked a medical diagnosis. R48's medical record did not | 2 910 | Corrected | |

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indicate R48 had a comprehensive bladder assessment completed when the Foley catheter was placed.

R48's physician's order dated 8/31/17, indicated R48 had an indwelling Foley catheter with direction for hospice to place and maintain. The order lacked a diagnosis for the Foley catheter.

R48's physician's order dated 10/2/17, included a diagnosis of incontinence and nocturia for use of the Foley catheter.

On 10/2/17, at 2:40 p.m. assistant director of nursing (ADON)-A stated R48 had an indwelling Foley catheter for incontinence and nocturia.

During interview on 10/5/17, at 9:12 a.m. ADON-C stated she felt incontinence and nocturia was not a reason to place a Foley catheter.

During interview on 10/5/17, at 10:14 a.m. ADON-A stated the physician diagnosis on 10/2/17, was obtained at that time because R48's record lacked a diagnosis for the use of a Foley catheter when requested by the surveyor. ADON-A stated hospice placed the Foley catheter prior to her start of employment at the facility, however, she felt education should have been given to hospice prior to placing the catheter, as incontinence and nocturia were not acceptable reasons to place a Foley catheter. ADON- A stated if R48 was having issues with frequency of urination a comprehensive bladder assessment should have been completed. She indicated prior to use of the catheter, alternatives should of been considered such as offering a bed pan, overnight briefs, medication review, and review of R48's sleeping patterns.

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During telephone interview on 10/5/17, at 11:25 a.m. hospice registered nurse (RN)-F stated the catheter was placed as R48 had complaints of having to get up out of bed every two hours to urinate. RN-F stated R48 did have pain, but it was managed by her current pain medications.

The facility policy Indwelling Catheter dated 7/15, indicated: "The center strives to ensure that a resident who enters a center without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. All residents with an indwelling catheter require a medical justification for the initiation and continuing need for catheter use. A comprehensive assessment includes underlying factors supporting medical justification, determination of which factors can be reversed and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days."

R134's significant change MDS dated 07/13/17, indicated he was severely cognitively impaired, needed extensive assist of two with toileting and was always continent of urine. R134's MDS failed to indicate he had a catheter. R134's care plan dated 10/17, indicated he had a history of urinary tract infections and had a Foley catheter. R134's Urinary Incontinence Care Area Assessment (CAA) dated 7/27/17, indicated he needed total dependence with toileting and was incontinent of bowel and bladder and staff managed all incontinence cares and used incontinent products. The CAA assessment indicated he had urinary urgency and needed assistance with toileting. The CAA failed to indicate he had a catheter.

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R134's hospice care plan dated 07/07/17, indicated he had alteration in bladder elimination and had an indwelling urinary catheter.

On 10/03/17, at 8:22 a.m. R134 was observed in the dining room to have a catheter bag attached below his Broda chair (tilt and space positioning chair).

During interview on 10/05/17, at 8:43 a.m. assistant director of nursing (ADON)-B stated R134 had went to the hospital in July 2017 when he was on third floor and transferred to first floor when he returned from the hospital. ADON-B stated his catheter bag should be changed weekly and the catheter should be changed monthly. ADON-B stated this was not put on his orders when he returned from the hospital and she was not sure if either had been completed since they had no orders.

During observation 10/05/17, at 8:59 a.m. R134 was observed in bed. His indwelling catheter was observed attached to the left side of the bed. The catheter anti-reflux valve and tubing inside was covered in a thick, mucus grey matter.

During interview on 10/05/17, at 9:00 a.m. nursing assistant (NA)-J stated he did not normally see grey sediment on a catheter. He indicated R134 had been in the hospital and returned on first floor with the catheter. NA-J stated staff empty the catheter bag each shift.

During interview on 10/05/17, at 9:11 a.m. ADON-B stated the facility should have orders on when to change the catheter, bag and tubing and indicated she was unable to locate orders for R134. ADON-B stated she would assume staff had not changed the catheter, tubing and bag

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since he returned from the hospital on 07/05/17 (almost two months). ADON-B further stated she noticed the sediment in the catheter and did not know why he had a catheter since he never had one before his hospitalization. ADON-B stated the catheter was placed in the hospital on 6/23/17, and the record did not indicate the reason for the catheter.

During interview on 10/05/17, ADON-B stated she had contacted R134's physician and received orders to remove the catheter since the facility did not have a reason for R134 to have the catheter. ADON-B further indicated she had taken his vital signs and his temperature was 98.2 and had no signs of sepsis.

Although R134 had a indwelling catheter the facility failed to have medical justification for the catheter and orders to maintain the catheter.

A facility Procedure Indwelling Urinary Catheter effective July 2015, included to inform care giving team of plan, educate on techniques and interventions as indicated.

URINARY INCONTINENCE

R55's quarterly MDS dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with toileting. The MDS included a diagnosis of dementia and had moisture associated skin damage. The MDS also identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. A trial toileting program had not been attempted since admission. R55's Urinary Incontinence

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CAA dated 12/19/16, indicated R55 triggered for further assessment due to extensive assistance with toileting and was always incontinent of urine. Modifiable factors contributing to incontinence included: pain, urinary tract infection, constipation and restricted mobility. Other factors listed were urinary urgency and need for assistance in toileting. A care plan was to be developed to maintain R55's current level of functioning.

The facility was unable to provide a comprehensive bladder assessment completed for R55.

R55's Urinary Continence care plan, revised on 7/17/17, indicated R55 had functional incontinence and included interventions of prompted voiding upon rising, before and after meals, at bedtime and individualized times. The care plan did not identify the individualized times. The care plan also indicated R55 was to use an adult pull up and for staff to change the pull up as needed.

R55's undated nursing assistant care sheet indicated R55 had "functional incont. [incontinence] upon rising, before and after meals and at bedtime. " The nursing assistant care sheet did not direct staff on what type of assistance R55 needed with toileting.

During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap. During this time, R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting with her. At 11:18 a.m. the social services director (SSD) brought R55 onto the elevator to bring her for a cigarette. SSD did

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not address R55's urinary incontinence.

During interview on 10/3/17, at 11:02 a.m. health unit coordinator (HUC), who indicated she was at the nursing desk for a large part of the day, stated R55 was soiled with urine about three to four times a week.

During observation on 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevators and nursing desk. R55 stated she was waiting to go out for a cigarette at 9:00 a.m.. At 7:08 a.m. assistant executive director (AED)-B took R55 outside to smoke, after smoking AED-B brought R55 back to the 4th floor and brought her to the dining room for breakfast. At 8:07 a.m. after breakfast, NA-H brought R55 to her room and cleaned her nails. NA-H did not offer to toilet R55 at this time following breakfast and after R55's nails were cleaned, she moved R55 back to the area near the elevator and nursing desk. At 8:56 a.m. NA-I brought R55 to her room and assisted with removal of her chin hair and clipped her nails. NA-I did not offer to toilet R55 at this time. At 9:05 a.m. R55 was assisted outside to smoke by NA-I. At 9:08 a.m., after smoking, NA-I wheeled R55 to the dining room to watch television at 9:08 a.m. NA-I did not offer assistance with toileting at that time.

During interview on 10/4/17, at 9:43 a.m. NA-I was not sure when R55 had last been toileted. NA-I stated NA-H was assigned to her for the day and she only shaved her chin and cut her nails. NA-I stated she did not offer to toilet R55 during those cares.

During interview on 10/4/17, at 9:46 a.m. NA-H stated she had not toileted R55 today, but R55 was incontinent of urine when she woke her up

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that morning and changed her brief. Further, NA-H stated the staff do not toilet R55, but check and change her brief once in the morning and once in the afternoon, when the staff lay her down for a nap. NA-H stated the staff would change her in between those times if her pants are wet. NA-H stated after assisting another resident she would bring R55 back to her room and check her pad.

During observation on 10/4/17, at 9:55 a.m. NA-H brought R55 back to her room. R55 indicated there were no sheets on the bed because, "I probably wet them last night." R55 further stated she would like to go on the toilet, but the staff just check and change her brief. NA-H then assisted R55 to transfer from her wheelchair to her bed. With gloved hands NA-H changed R55's incontinent brief, which was saturated with urine. NA-H stated R55's brief had a large amount of urine in it. Further, she had to remove R55's bed linens that morning because the linens were wet with urine. She indicated it was usual to change R55's linens in the morning because the linens were wet.

During interview on 10/5/17, at 10:01 a.m. ADON-A stated R55 did not have a current bladder assessment. ADON-A stated per the care plan, R55's incontinence was functional and related to inability to transfer herself. ADON-A stated a bladder assessment should include 72 hours of bladder monitoring to effectively determine R55's toileting patterns and subsequent scheduling needs. ADON-A further stated R55 was to be toileted and not checked and changed. ADON-A indicated R55 needed to be reassessed for her toileting needs as she had never seen R55 toileted. ADON-A also stated R55 was not being toileted according to her current care plan of upon rising, before and after

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meals and at HS.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance for toileting. The MDS identified diagnoses of benign prostatic hyperplasia (BPH) and schizophrenia. The MDS also identified R2 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. The MDS indicated a trial toileting program had been attempted with no improvement noted and R2 was on a current toileting program. R2's Urinary Incontinence CAA dated 8/19/17, indicated R2 triggered for further assessment due to extensive assistance with toileting and was frequently incontinent of urine, as well as moisture associated skin damage. Modifiable factors contributing to incontinence included: psychological or psychiatric problems and restricted mobility. Other factors listed were urinary urgency and need for assistance in toileting. A care plan was to be developed to improve R2's current level of functioning and avoid complications.

R2's Bladder Data Collection and Assessment dated 4/4/16, and reviewed on 5/11/17, indicated R2 was always incontinent. Signs and symptoms included: "clothes wet, bedwetting, and wears pads." The assessment also indicated R2 had excessive intake of caffeine beverages and / or bladder irritants. The assessment identified R2 had urge and functional incontinence with a treatment program of prompted voiding, however, no scheduled times were provided for the prompted voiding program.

R2's Urinary Continence care plan last reviewed 8/4/17, indicated R2 was incontinent and resident

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refused to wear incontinent products and occasionally soiled self. The care plan included a behavior which indicated R2 would lie in bed and urinate, soiling himself and the bed and refused to be changed was noted. However, the care plan did not address how the staff should handle the behavior, other than to encourage him to change his clothing. The care plan indicated to provide R2 with incontinent briefs and directed staff to offer prompted voiding at individualized times of offering every two hours and as needed. The care plan also directed staff to check and change R2 at individualized times as resident refuses to toilet himself. The care plan did not include individualized times for toileting needs for R2 and listed conflicting information of toileting and check and change.

R2's undated nursing assistant care sheet directed staff to "remind to toilet q2h [every two hours], chart both inc [incontinent] and cont. [continent]."

During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweatpants were wet in the front and back, as well as the right lower side of his shirt. Multiple staff were located around the nursing desk and no staff members offered to assist him with toileting. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated. R2's room had a strong odor of urine present that could also be smelled in the hallway.

During interview on 10/3/17, at 11:02 a.m. HUC stated R2 was soiled with urine about three to four times a week. She stated in the past, she had to direct R2 to his room to change out of urine soiled clothing, because the nursing staff

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did not have the time to assist him. HUC stated she directed R2 to his room to clean himself and change out of his wet clothes on 10/2/17, because the nursing staff did not have time to assist him.

During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff were aware when R2 was soiled, but were unable to assist R2 due to the lack of staffing.

During interview on 10/5/17, at 9:39 a.m. ADON-A stated she did not recall seeing R2 walking around with clothing saturated with urine on 10/2/17, however, staff should have assisted him. ADON-A stated R2 should have been offered to toilet and any refusals should be charted and the nurse alerted, so other staff could try and assist R2. ADON-A stated she was aware R2 removed and refused to wear briefs, but was not sure if adult pull ups had been tried. After reviewing R2's bladder assessment dated 5/11/17, ADON-A stated she did not agree with the assessment and felt R2 needed to be re-assessed and interventions looked at as she was not sure why there were no individualized times set for toileting R2.

R2's Behavior Detail Report from 7/7/17 to 10/4/17, indicated R2 resisted care one time on 9/16/17, and staff was able to redirect R2. The report did not include any further incidents of resisting care.

The facility policy Urinary Incontinence dated 7/15, indicated: "The center strives to ensure that

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| 2 910 | Continued From page 122<br>residents who are incontinent of bladder receive appropriate treatment and services to restore as much normal bladder function as possible." The policy directed: "The care process is followed (accurate assessment, care planning, consistent implementation and monitoring of the care plan with evaluation of the effectiveness of the interventions and revision, as appropriate) to appropriately manage urinary incontinence. Recording and evaluating specific information (such as frequency and times of incontinence and toileting and response to specific interventions) is important for determining progress, changes, or decline. Various conditions or situations may aggravate the severity of urinary incontinence. Steps should be taken to alter these conditions/situations whenever possible."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could develop and or revise policies for use of an indwelling catheter and assessment of bladder function. The DON or designee could educate the responsible staff on these policies. The DON and /or designee could conduct audits of residents with bladder incontinence and or use of an indwelling catheter to ensure comprehensive bladder assessments are done and to ensure medical justification for the continued use of indwelling catheters are being done.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 910 | | |
| 2 920 | MN Rule 4658.0525 Subp. 6 B Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing | 2 920 | | 11/13/17 |

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| 2 920 | Continued From page 123<br>home must ensure that:<br>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure residents were assisted with personal hygiene for 3 of 5 residents (R55, R2, R183) reviewed for activities of daily living (ADL) and who were dependent on staff for care.<br><br>Findings include:<br><br>R55's quarterly Minimum Data Set (MDS) dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine, with moisture associated skin damage. Diagnoses included dementia and depression.<br><br>R55's ADL/Mobility care plan last dated 4/10/17, included a goal for R55 to be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene and dressing.<br><br>On 10/1/17, at 9:50 a.m. R55 was seated in her wheelchair in the doorway to her room. A dark brown substance was noted to be under her long fingernails on her right hand.<br><br>During observation on 10/1/17, at 11:10 a.m. R55 | 2 920 | Corrected | |

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was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap. During this time R55 was loudly requesting to go outside for a cigarette, as staff passed by her, not interacting with her. At 11:18 a.m. the social services director (SSD) brought R55 onto the elevator to bring her for a cigarette. SSD did not address R55's urinary incontinence.

During subsequent observation on 10/3/17, at 9:58 p.m. R55 continued to have a dark brown substance under her long fingernails on her right hand. At this time registered nurse (RN)-A bent down next to R55 and asked her how she was. R55 stated she was fine and RN-A continued to the elevator.

On 10/3/17, at 11:43 p.m. R55 was seating in her wheelchair in the dining room. R55 used her right hand, which continued to have a dark brown substance under her fingernails, and picked a potato out of her potato salad and placed it in her mouth. At 1:52 p.m. nursing assistants (NA)-C and NA-R transferred R55 to her bed. Neither NA-C or NA-R offered to clean R55's fingernails. NA-C stated nail care was done on residents' bath days by the nursing assistants unless they were diabetic, then the nurse did the nail care.

On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.

R55's bath list indicated she received showers on Tuesday evening (which would have been 10/3/17).

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During observation on 10/4/17, at 7:08 a.m. assistant executive director (AED)-B assisted R55 outside to smoke. R55 held her cigarette in her right hand and AED-B lit her cigarette. AED-B never offered to have R55's nails cleaned and brought her back upstairs to the 4th floor dining room for breakfast.

During observation on 10/4/17, at 8:07 a.m. NA-H brought R55 out of the dining room back to R55's room and started cleaning her fingernails. NA-H stated her nails were "really really dirty" and they should be cleaned every day. NA-H stated she noticed they were dirty when she got her up this morning, however, someone brought her out to smoke before she had a chance to clean them. NA-H stated nail care should be done as needed and on their bath days. NA-H confirmed R55 was scheduled for a shower the evening before and nail care should have been done.

During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)-A stated nail care should be done daily with cares if visibly dirty, otherwise weekly with their showers. ADON-A stated resident should not be sitting in urine soiled clothing.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R2 was frequently incontinent of urine, with moisture associated skin damage. Diagnosis included was schizophrenia. R2's ADL Care Area Assessment (CAA) dated 8/19/17, indicated R2 was at risk of a functional decline due to psychoactive medications, physical limitations, falls, complications of mobility including incontinence,

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weight loss and depression. A care plan was to be developed to slow or minimize a decline, avoid complications and minimize risks. The CAA directed to see care plans for problems, goals and interventions.

R2's ADL/Mobility last reviewed on 8/5/17, indicated R2 would be neat, clean and well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADLs and at times refused shaving. The care plan lacked approaches to refusal of cares.

During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweatpants were saturated with urine in the front and back, as well as the right lower side of his shirt. R2's hair was uncombed and sticking up in multiple places. Multiple staff were located around the nursing desk and no one offered to take him back to his room to assist with changing his clothes and combing his hair. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated with urine. R2's room had a strong odor of urine present that could be smelled in the hallway.

On 10/3/17, at 10:12 a.m. R2 was walking in the hallway in front of the nursing desk, his shoes were untied, his hair was uncombed and sticking up in multiple places, his gray t-shirt had a tear in the back of the collar from one side of the neck to the other. ADON-A approached R2 and offered to tie his shoes. R2 allowed ADON-A to tie his shoes, however ADON-A did not offer to take him

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back to his room and help him change his shirt or comb his hair.

On 10/4/17, at 6:51 a.m. R2 was sitting in the dining room watching television. His hair was uncombed and was sticking up in multiple places. His gray t-shirt had a quarter sized hole in the front. R2 was in the dining room until 9:06 a.m. when he walked down the hall towards his room and laid in bed. Staff did not approach R2 and offer to change his shirt or comb his hair, during this time.

During interview on 10/4/17, at 8:47 a.m. social services assistant (SS)-A stated R2 had a brother that he had contacted in the past about getting new shoes and the brother bought him a new pair. SS-A stated he had not noticed the holes in R2's clothing and had not notified R2's brother for help in obtaining new clothing. SS-A stated it was a residents right to wear what they wanted, however, R2 would never complain about having holes in his clothing unless they were really large.

During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are aware when R2 was soiled, and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and was not sure who did. NA-G stated he was fairly independent but needed hands on assistance frequently and did allow staff to comb his hair and assist with changing his clothes, it just depended on how staff approached him.

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| 2 920 | Continued From page 128<br><br>R2's Behavior Detail Report from 7/7/17 to 10/4/17, indicated R2 resisted care one time on 9/16/17, and staff was able to redirect R2.<br><br>During interview on 10/5/17, at 9:39 a.m. ADON-A stated in the past R2 had done some of his own personal cares, however, staff should be offering assistance as needed. Although, R2 is to be offered toileting and assistance every two hours, staff should have assisted him with changing his clothing soiled with urine. Any refusals needed to be charted and reported to a nurse so others could try and assist with needed cares. ADON-A stated a lot of residents have holes in there clothes and have no one to buy them any. She was aware R2 had clothing with holes, however, did not recall if she communicated R2's need to social services for assistance. Staff should be helping R2 with combing his hair. ADON-A also stated R2's care plan needed to be looked at further for accuracy.<br><br>R183's Admission Record, dated 10/5/17, identified multiple medical diagnoses including heart failure, diabetes, morbid obesity, hypertension, lymphedema, chronic respiratory failure and urinary retention.<br><br>R183's admission MDS dated 8/3/17, identified R183 had intact cognition with moderate symptoms of depression. R183 required extensive assistance to complete all ADL's except eating, had an indwelling catheter and did not ambulate.<br><br>A review of R183's care plan dated 7/28/17, identified R183 required personal assistance with personal hygiene/grooming/dressing/undressing. R183's care plan did not list interventions to use | 2 920 | | |

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to maintain R183's hygiene and meet his bathing needs.

On 10/1/17, at 3:44 p.m. R183 was noted to be resting on his bed, covered only with a sheet. R183 was noted to have a strong, pungent odor of perspiration and other body odors. A straight urinary drainage bag was noted attached to the bed frame, and tubing from the bag was observed under the sheet. R183 stated he was dependent on staff for provision of care stating, " I can turn my light on, but I don't know how long it will take them to come." R183 did acknowledged he had called 911 when he had been left on the commode for 45 minutes. He stated the staff responded within five minutes after he called. R183 stated his bath is scheduled for Mondays, but had not yet received one since admission to the facility greater than two months ago. R183 stated to receive a shower he would need to be transported on a gurney and assisted to shower while on the cart. R183 stated he has received "A whore bath," when he was assisted to wash up with a basin.

During interview on 10/2/17, at 12:23 p.m. R183 stated he was going to get dressed today but did not feel real clean. R183 stated his last bed bath was about two weeks ago. R183 was noted to be dressed in a hospital gown at this time and was noted to have an increase of strong, pungent body odor that had been noted on 10/1/17. The strong, pungent body odor was very prominent in the room, and also notable in the hallway outside of the R183's room. R183 stated he chose not to get up for lunch, and stated it would take too long to get back to bed, would become uncomfortable and had a history of pressure ulcers. Following interview, the bath schedule was noted to be posted at nurses station and identified R183

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received his bath on Tuesday evenings.

During interview on 10/4/17, at 7:05 a.m. R183 stated he had received a bed bath last evening. R183 stated after his bed bath he requested to get up out of bed and was asked why he wished to get up. R183 stated he had to instruct staff to change linens following his bath as he wished to have fresh linens. R183 stated his linens were changed as requested.

During interview on 10/4/17, at 2:19 p.m. nursing assistant (NA)-S stated he had provided assistance for a bed bath for R183 and stated he felt he had provided care according to R183's care plan. NA-S stated the resident can also identify what they want. NA-S stated he had performed catheter hygiene for R183.

A review of R183's physician progress notes of 10/2/17, identified R183 did not wish to pursue catheter removal noting, "I can't even get someone here to help me shit. I won't be demeaned any further."

During interview on 10/5/17, at 9:59 a.m. the ADON-B stated R183 was very impatient and went on to state if he does not receive immediate assistance, he will attempt to self transfer, or call 911. ADON-B stated the call light should be answered immediately, with assistance provided within ten minutes, however, it may take longer to summon adequate staff to provide assist of two for transfers. ADON-B stated she was unaware of concerns regarding personal odors, and expressed it was the expectation residents were washed up with morning and bedtime cares, including washing of face, hands, pericare, armpits, and application of lotion and deodorant. ADON-B stated residents hair are routinely

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washed on bath day.

Review of R183's resident care tracker from 9/28/17 through 10/3/17, was done with ADON-B. The resident care tracker had notations made R183 had received two bedbaths in one day at times. ADON-B stated he would not of gotten two bedbaths in a day and felt the documentation had been completed incorrectly. ADON-B indicated she was not aware if R183 had received a shower, but stated if short staff and unable to complete the shower, the task would be passed on to the oncoming shift to complete. The ADON-B stated it would be appropriate for him to be washed up and receive a bath at the time the odor was noted.

A request for provision of bathing process was also requested and not provided.

The facility policy Activities of Daily Living (ADL) Program dated 7/15, included: "Determine if the resident has specific tasks and areas requiring ADL assistance. Bathing, dressing and grooming techniques and interventions may include, but are not limited to:"

- Selecting and obtaining clothes
- Putting clothes on
- Fastening buttons and snaps
- Taking off all items of clothing
- Applying or removing braces and artificial limbs
- Use of adaptive equipment
- Maintaining personal hygiene
- Planning the task
- Gathering supplies
- Combing hair
- Washing face and hands
- Brushing teeth
- Shaving if applicable

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| 2 920 | Continued From page 132<br>· Applying deodorant<br>· Applying make-up if applicable<br>· Trimming nails<br>· Use of adaptive equipment<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 920 | | |
| 2 955 | MN Rule 4658.0530 Subp. 3 Assistance with Eating - Risk of Choking<br><br>Subp. 3. Risk of choking. A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R19) identified with swallowing difficulties | 2 955 | Corrected | 11/13/17 |

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received safe and appropriate assistance with eating. A non-trained paid feeding assistant/staff member, Human Resources (HR)-A, assisted with feeding a resident who had a history of aspiration pneumonia and a complicated feeding problem. R19 was observed coughing while being fed by HR-A. Even though nursing staff were directly across the table while this occurred, they did not intervene placing R19 at risk. The findings constituted an immediate jeopardy (IJ) situation for R19, with the potential for serious harm, injury or death.

The facility also failed to ensure residents who were fed by a paid feeding assistants (PFA) were appropriately assessed to be fed by a PFA, and receive training through a state approved program for 2 of 2 (R19, R97) residents who were observed to be fed by a PFA. R97 did not have swallowing problems but needed staff assistance with eating.

The immediate jeopardy began on 10/04/17, at 8:12 a.m. when HR-A was observed to assist R19 with eating, who had a complicated feeding problem and was having difficulty swallowing. The executive director (ED), interim director of nursing (DON), director of clinical services (DOCS), assistant ED-A and ED-B were informed of the immediate jeopardy on 10/04/17, at 4:15 p.m.. The IJ was removed on 10/05/17, at 2:54 p.m., but non-compliance remained at the lower scope and severity of (D) isolated, with potential for more than minimal harm that is not Immediate Jeopardy.

Findings include:

During entrance interview on 10/01/17, at 12:16 p.m. with the adminstrator and the interim director

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of nursing (DON) both stated they did not have a paid feeding assistance program (PFA) to assist residents with eating.

R19's Admission Record undated indicated that he had dementia and dysphagia (difficulty swallowing). R19's Minimum Data Set (MDS) dated 09/08/17, indicated he needed extensive assistance of one with eating and had no swallowing disorders. R19's Nutritional Status Care Area Assessment (CAA) dated 09/13/17, indicated he required assistance with feeding at meals and had a need for special diet or altered consistency which might not appeal to resident. The CAA further indicated he received sufficient eating assistance.

A Discharge Summary Note dated 12/02/16, from North Memorial Medical Center, indicated he was hospitalized from 11/30/16 to 12/02/16. The Discharge Summary note identified he had aspiration pneumonia, and x-ray with bilateral infiltrates (something that has gotten in to the lungs from the outside. Any abnormal density will show up in the otherwise air filled lungs. Usually the infiltrate will mean pneumonia, or some sort of infection with edema/swelling that is in the lung).

R19's Nutrition Risk Care Plan dated 9/08/17, indicated he received a pureed diet with honey thickened liquids and needed total assistance to the dining room and reminded of meal times. The care plan did not list specific speech therapy recommendations.

Review of R19's diet card, undated, indicated he needed total assistance to be fed and received honey thickened liquids and a pureed diet. In addition, R19's nursing assistant care sheet,

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undated, indicated his liquids were honey consistency and he needed total assistance with eating with a note, "see ST [speech therapy] instruction."

R19's speech therapist note dated 8/02/17, indicated PT (patient) seen for skilled ST services to address dysphagia and complete final session to receive discharge documentation. Therapist followed up with nursing staff regarding use of printed compensatory swallowing strategies to reduce aspiration risk. A 24-hour log updated for discontinuation of services due to inability to progress due to dementia and inability to follow cues. Nursing staff to implement use of compensatory swallowing strategies and monitor for ongoing signs and symptoms of aspiration.

A 24 Hour Status Report dated 8/02/17, indicated: "D/C [discontinue] from ST today continue puree/honey thick liquid diet. Printed strategies at patient's table to follow during meals."

The speech therapy instruction sheet indicated the following:
* Bite sizes should be 1/2 spoonful of puree
* Use spoon to give honey thickened fluids (1/2 spoon size)
*Allow patient to clear mouth completely before giving another bite
* Do not put more food in patient's mouth if he is still chewing
* If he begins coughing, do not give more food until coughing discontinues.

During observation on 10/01/17, at 12:12 p.m. nursing assistant (NA)-B was observed to give R19 a drink of his juice brining his cup of honey thickened liquids to his mouth and having him drink it instead of using a spoon as required. She

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proceeded to have him take three drinks and R19 started to cough while drinking from the cup. NA-B stopped when he coughed waited for him to stop and then continued to give him a teaspoon full of his potatoes, and then a teaspoon of his pureed roast beef and he coughed again. At 12:19 p.m. she fed him a level teaspoon full of his mashed potatoes and he coughed again, then NA-B stated to R19 'It's ok" and gave him a drink of his juice from his cup. At 12:20 p.m. surveyor intervened and asked NA-B if she was aware of R19's specific feeding recommendations from the speech language pathologist (SLP)-A and showed her the instructions that were on the window sill of the dining room. NA-B stated she was not aware and NA-M instructed her that he should only receive 1/2 teaspoons of food and liquids at a time. NA-B then took the teaspoon at the table and placed in his honey thickened juice and proceeded to feed him 1/2 teaspoons of his food and beverages and his coughing had decreased.

During observation 10/04/17, at 8:12 a.m. HR-A was observed in the first floor dining room assisting R19 with eating. R19 had scrambled eggs, pureed sausage, oatmeal and honey thickened cranberry juice. At the same table directly across from HR-A, sat assistant director of nursing (ADON)-B whom was assisting R134 with eating. HR-A gave R19 a level teaspoon full of pureed sausage and then immediately gave a heaping teaspoonful of his oatmeal, without first waiting for R19 to swallow the spoonful of pureed sausage before immediately giving a heaping spoonful of oatmeal to R19. R19 immediately started to cough, loudly turning his head away from HR-A to the right. HR-A stopped feeding him and rubbed his back and waited for him to stop coughing. HR-A then brought R19's glass of

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honey thickened cranberry juice just below his chin and began spoon feeding R19 three spoonfuls of thickened juice, one after another without first waiting for R19 to swallow each bite. HR-A fed R19 a full teaspoon of thickened juice, not a half teaspoon as identified by the ST swallowing strategies. HR-A proceeded to give R19 a heaping spoonful of his pureed sausage and R19 immediately began to cough. HR-A stopped again and let him cough without waiting and HR-A then brought R19's glass of honey thickened cranberry juice to his chin and quickly began feeding R19 three level teaspoonfuls of juice, and a level teaspoon full of oatmeal. HR-A did not wait for R19 to swallow each bite, before she gave him another bite to eat. R19 began to cough loudly and his face turned red while HR-A covered his mouth with his clothing protector while he coughed. ADON-B whom was directly across from HR-A while she fed R19, made no attempts to stop HR-A from feeding R19 even though HR-A was not following the ST swallowing strategies and R19 continued to cough while being fed. R19 had eaten 100% of his scrambled eggs, pureed sausage, and half of his oatmeal and 3/4 of his honey thickened cranberry juice. ADON-B left the same table HR-A was assisting R19 and NA-M then sat down to assist R134 across the same table R19 was sitting at. At approximately 8:25 a.m. SLP-A entered the dining room, and surveyor informed her of the above observation. HR-A was removing R19's clothing protector and SLP-A immediately walked up to the table and instructed HR-A she should have been following her recommendations of bite sizes which is 1/2 spoonful of liquids and food. HR-A then stated that NA-M had just informed her of the SLP instructions and she had stopped feeding R19.

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During interview 10/04/17, at 9:22 a.m. HR-A stated she had been working at the facility since 03/07/17, and became a NA in 2005, her NA certificate had expired in 2008, and she had not renewed her certificate. HR-A stated she assists with feeding when they are short staffed and had also assisted another resident (R97) on the fourth floor. HR-A stated she does not need to feed the resident on fourth floor but just makes sure she does not spill her food while she is feeding herself.

During interview on 10/04/17, at 12:20 p.m. NA-K stated she knows that when feeding R19 they are to give small amounts of food and then give liquids to make the food go down. NA-K stated she does not know if there was any size amounts of the food or liquids and he had a tendency to cough while being fed. She indicated his ticket says instructions on how he should be fed and it should also be on his care plan.

During interview on 10/04/17, at 12:25 p.m. licensed practical nurse (LPN)-D stated she was not aware of any feeding recommendations for R19 and added, "What I don't know I can't tell you!"

During interview on 10/04/17, at 12:42 p.m. SLP-A stated she had written up the instructions with his plan of care, and had made these recommendations for R19 on 7/24/17, and trained staff that assisted with feeding him. The SLP indicated she left the feeding instructions at the table where R19 ate and the instructions would disappear, so she would make new cards and leave them again at his table. SLP-A stated she also told the interim nurse manager during this time, but she no longer works at the facility. In addition, the SLP-A stated she wrote these

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recommendations on the 24 hour communication board for all staff to see. The SLP-A further stated R19 will cough while eating and she recommended a swallow evaluation awhile ago, but did not think the facility followed through on her recommendation. She relied heavily on the staff to follow through with her recommendations since he was at such high risk for aspiration and it was vital to follow through with SLP's recommendations. The SLP-A stated when she feed R19 1/2 teaspoons of his food and liquids he coughs much less and it reduced his risk of aspiration.

During interview on 10/04/17, at 1:01 p.m. assistant director of nursing (ADON)-B stated, "I don't know anything about a swallow evaluation." ADON-B added she had been working on the floor at the facility for six weeks which was prior to the SLP recommendation and indicated she could call his guardian. In addition, ADON-B stated she found out about R19's recommendations last Friday when she overheard a NA instruct another NA about how to feed him. ADON-B further indicated he gets pureed food and that you have to give it to him slowly and was not aware of any portion size but to just feed him slowly.

During interview on 10/04/17, at 3:06 p.m. ADON-B stated that administration told her that HR-A was a certified nursing assistant so she did not say anything to her about not assisting R19. ADON-B added she not realize she (HR-A) was not following his feeding instructions but once she found out she was not following his instructions she contacted respiratory therapy to do an evaluation and took his vital signs which were with in normal limits. In addition, ADON-B stated she placed a call out to R19's primary physician

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informing him of the facility not following the SLP-A feeding instructions and had not heard back from him. Further, ADON-B stated R19's instructions for feeding were not at the table during lunch today and a downfall they have at the facility is they keep rotating staff from different floors so they do not know the residents.

During interview on 10/4/17, at 3:32 p.m. NA-O stated R19 had coughed a lot while eating, was slow to eat, received thickened liquids and pureed food. NA-O stated they use a four ounce glass to assist R19 to drink. If R19 had coughing while using the glass with increased coughing, he would use a spoon for the thickened liquids and give a full teaspoon of fluid. Previously (approximately 3 months ago) there were written directions on the table that directed staff to use a spoon for fluids but these directions were removed from the table. They resumed to feed R19 as they did previously either with a glass or spoon, and monitor his response. NA-O was unaware he needed to give R19 half teaspoon of fluids and not use a glass.

During interview 10/04/17, at 3:42 p.m. NA-L stated an educator from the facility instructed her on R19's SLP-A recommendations but she stated, "I told her as soon as you walk away I won't remember what you told me. She didn't say anything and had me sign a paper saying I was educated." NA-L then stated, "I had not fed him since he was on his new diet."

On 10/5/17, at 8:07 a.m. the director of regional operations (DORO) stated HR-A was not directed by any management team member to assist with feeding and she had never done any type of feeding before; however, DORO then stated HR-A had been misleading the facility by telling

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facility staff members she was a nursing assistant. Although DORO identified this, there was no indication any management staff had checked with HR-A if her nursing assistant certification was current, even though they identified HR-A communicated to them she was a nursing assistant.

During interview 10/5/17, at 2:15 p.m. NA-Q stated she received new education and the staff needed to check the meal ticket for any special feeding instruction and directions that referred to the black book would be located on the beverage cart. A nurse needed to be in the dining room prior to staff serving resident and if anyone started coughing or choking they were to alert the nurse.

Interview on 10/5/17, at 2:17 p.m. licensed practical nurse (LPN)-F stated she had been educated on the new process regarding residents who have special diet. The ticket on the table would have the instructions and if needed would indicate to check the black book which would be located on the beverage cart. Nurse needed to be in the dining room prior to serving and supervise staff and assist if there were any issues with coughing or choking. Only trained staff can assist with feeding residents.

The immediate jeopardy that began on 10/4/17, at 8:12 a.m. was removed on 10/5/17, at 2:54 p.m. when it could be verified by observation, document review, and staff interview, the facility had educated dietary, ST and nursing staff of who could and could not feed residents, that a nurse needed to be in the dining room when residents were eating, where individual resident swallowing guidelines were located in the dining room, and what guidelines to follow to assist R19 and R97 to

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eat.

Although R19 had a history of aspiration pneumonia and was at risk for aspirating the facility failed to follow the SLP-A specific instructions while feeding R19, and ensure paid feeding assistants were appropriately trained. In addition, ADON-B and NA-M were directly across the table while HR-A was feeding R19 incorrectly, and made no attempts to stop or intervene while this occurred.

A policy was requested for following SLP recommendations but was not provided.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review/revise policy and provide education for staff regarding training for staff who assist residents with meals (paid feeding assistants). In addition, the DON and/or designee could ensure that appropriate comprehensive assessments are completed on residents to determine appropriateness of them being fed by a paid feeding assistant. The DON and/or designee could conduct audits to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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| 21250 | MN Rule 4658.0700 Subp. 2 F. Medical Director;PeriodicAdvisement to DNS | 21250 | | 11/13/17 |

Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for:

F. periodic advisement to the director of

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| 21250 | Continued From page 143<br>nursing services to ensure a quality level of delegated medical care provided to residents; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure on-going collaboration with the medical director to ensure identified quality concerns related to activities of daily living (ADLs) and insufficient staffing were adequately addressed and resolved. This had potential to affect all 94 residents in the facility.<br><br>Findings include:<br><br>A Centers for Medicare and Medicaid Services (CMS) 2567 report dated 7/10/17, identified an abbreviated standard survey had been conducted at the facility related to four separate complaint investigations which had been filed with the State agency (SA). The survey resulted in several deficiencies being cited, including examples at F282 (not implementing the written plan of care), F312 (not providing activities of daily living for dependent residents), and F353 (not providing adequate staffing to meet residents' assessed needs). The facility listed a plan of correction for each of these identified concerns, all of which had a completion date identified of 8/16/17.<br><br>During the current recertification survey, the following examples of continued concern(s) were identified:<br><br>The facility did not provide cares as identified on the care plan for 2 resident who required staff assistance for repositioning; 1 resident whom | 21250 | Corrected | |

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| 21250 | Continued From page 144<br>required range of motion. Pressure ulcer monitoring not completed for 1 resident with a stage 3 pressure ulcer, and activities of daily living (ADL's) were not provided for 3 residents who were dependent upon staff for ADL's. See F282 for additional information.<br><br>The facility did not provide assistance for nail care, bathing and personal hygiene which resulted in residents having dirty nails, greasy unkept hair, and strong pungent urine and body odor for 3 residents who were dependent upon staff for activities of daily. See F312 for additional information.<br><br>The facility did not provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 residents whom were dependent upon staff for ADL's, 2 residents who had pressure ulcers, 1 residents with range of motion needs, 2 residents who were not fed by authorized staff due to limited staffing need. In additional there were 16 residents and 14 staff members whom voiced concerns about the lack of sufficient nursing staff to provide care and services to residents in the facility. Refer to F353 for additional information<br><br>When interviewed on 10/5/17, at 2:33 p.m. the medical director (MD)-A stated he came to the facility on a regular basis for scheduled meetings. MD-A stated he was aware the facility had some concerns related to staffing and rapid personnel turn-over which had, "cut across all," levels of the facility. MD-A stated he was aware the facility had been cited in the past for staffing concerns, however, was not fully aware of all the identified care concerns (i.e. grooming not being completed, lack of timely repositioning to prevent skin breakdown, and bathing not being done) which had also been found. MD-A stated he and | 21250 | | |

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facility administration had reviewed the cited SA findings at a meeting recently, however, some of the plans to address them must had been, "put on the back burner," or, "we're never looked at again." MD-A stated the continued concerns of cares not being completed for residents, "certainly would be issues," which he should be included on to help develop a plan with, "what needs to be done," to correct them. Further, MD-A stated he was unaware the facility had an immediate jeopardy (IJ) determination on their current survey from two days prior, on 10/3/17, and he would call the facility to discuss this immediately.

On 10/5/17, at 2:56 p.m. the current executive director (ED), assistant executive director (AED)-A, and registered nurse director of quality (DOQ) were interviewed. DOQ stated MD-A was a, "huge support," to the facility and available readily when questions or needs arose from staff. DOQ stated MD-A had been made aware of the deficiencies cited during the last complaint survey, however, added she was, "unaware," of his involvement with developing any action plans to address them. Further, DOQ stated they should have involved MD-A more when addressing the identified concerns.

A facility Medical Director Agreement dated 6/10/16, identified MD-A to be the current, acting medical director for the facility. The agreement listed objectives including to have the medical director, "... ensure that residents at the Facility receive quality medical care," and, " ... assisting in the monitoring of resident care polices and coordinating medical care in the Facility." Further, the agreement listed several responsibilities of the medical director including, "Provide medical direction and overall

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| 21250 | Continued From page 146<br>coordination of medical care in the Facility," and, "Be responsible for evaluating and taking appropriate steps to correct situations of possible inadequate medical care that is identified by or reported to the Medical Director."<br><br>SUGGESTED METHOD OF CORRECTION: The corporate owner(s) and or designees could review their policy to ensure they followed industry standards for medical director involvement. The corporate owners or designees could have ongoing meetings with the MD to ensure ongoing communication and coloration in areas of resident cares, staffing patterns and staff competency to ensure resident needs are consistently met. The administrator could monitor this process as part of QA to ensure MD is aware of concerns and involvement with resident care at the facility.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21250 | | |
| 21330 | MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser<br><br>Subp. 2. Annual dental visit.<br>A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission.<br>B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental | 21330 | | 11/13/17 |

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| 21330 | Continued From page 147<br>examination or within one year from the date of the examination done within the six months before admission.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a dental referral was followed through to address dental concerns for 1 of 1 residents (R162) reviewed for dental concerns.<br><br>Findings include:<br><br>R162's annual Minimum Data Set (MDS) dated 5/20/17, identified R162 had no cognitive impairment and required extensive assistance with personal hygiene. R162's Admission Record, undated, identified R162's payer source to be Medicaid. The Admission Record further indicated he had been admitted on 05/09/17.<br><br>R162's Nutrition Risk Data Collection dated 08/16/17, identified R162 had no chewing or swallowing problems.<br><br>During interview on 10/02/17, at 12:36 p.m. R162 stated he had lots of problems with cavities and had a filling that had fallen out within the last year. R162 stated he went to the dentist last summer and had all of his teeth done, but since then has had problems with cavities and a lost filling. R162 stated when he admitted to the facility he had requested to see a dentist.<br><br>Review of R162's medical record indicated that on 05/12/17, he had requested a referral with Door Step Healthcare Services for dental | 21330 | Corrected | |

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treatment.

A Golden Valley Rehab & Care Center Communication Result Report dated 05/23/17, at 1:57 p.m. indicated a referral was sent to Doorstep and confirmation of receiving the referral from Doorstep was received on 05/23/17, at 1:58 p.m..

During interview on 10/03/17, at 8:46 a.m. medical records director (MR)-A stated R162 makes his own decisions and he signed up for dental services when he admitted. MR-A then indicated a referral was faxed on 05/23/17, and that she had confirmation they received the fax. MR-A stated the dental service comes out monthly and did not know why he was not seen. In addtion, MR-A stated once the referral is sent to Doorstop they leave it up to them to schedule the appointment and that no one in the facility tracks if they are seen or not after the referral is sent.

Although R162 addressed concerns of his teeth the facility failed to follow thru to ensure he was seen by a dentist as he had requested upon admission on 05/23/17, almost five months later.

SUGGESTED METHOD OF CORRECTION: The director or nursing and/or designee could develop and or revise policies for provision of dental services and educate responsible staff to ensure follow up dental needs are scheduled and residents are assisted in arranging tranportation when residents request. The DON and/or designee could conduct audits of residents with dental needs to ensure residents recieve dental services consistently.

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| 21330 | Continued From page 149<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21330 | | |
| 21390 | MN Rule 4658.0800 Subp. 4 A-I Infection Control<br><br>Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:<br>A. surveillance based on systematic data collection to identify nosocomial infections in residents;<br>B. a system for detection, investigation, and control of outbreaks of infectious diseases;<br>C. isolation and precautions systems to reduce risk of transmission of infectious agents;<br>D. in-service education in infection prevention and control;<br>E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;<br>F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;<br>G. a system for reviewing antibiotic use;<br>H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and<br>I. methods for maintaining awareness of current standards of practice in infection control.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement a | 21390 | Corrected | 11/13/17 |

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comprehensive infection control program to include consistent tracking, and analysis of infections to prevent potential spread to other persons which had the potential to affect 94 current residents, staff and visitors to the facility. The facility failed to ensure they had developed a water-management program to identify risks and develop policy to prevent Legionella exposure, which had potential to affect all 94 current residents of the facilty. Further, the facility failed to ensure a community-based glucometer was cleansed in accordance with manufacturer guidelines to prevent cross contamination of blood-borne pathogens for 2 of 2 residents (R31, R89) observed during their blood glucose monitoring, which had the potenital to affect 8 residents on the first floor with current blood glucose monitoring orders. In addition, the facility failed to ensure staff infection control practices were being implemented during a dressing change for 1 of 1 residents (R121) observed during wound care.

Findings include:

INFECTION CONTROL PROGRAM:

On 10/3/2017, in the afternoon, the assistant director of nursing (ADON)-C provided a three-ringed binder containing the facilty's infection control monitoring program. The binder included month divider tabs, and upon inspection, there were documents filed only under August and September 2017. Review of the materials identified the following:

September 2017:
A Monthly Line Listing Report/Monthly Healthcare Associated Infection Incident Rate worksheet was filled with sixteen (16) infection line listings, which

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identified, among other items: resident, room number, type of infection, onset date, if a culture was done, type of antibiotic and start date, and if the infection was acquired in house or not. There was an overall infection rate (3.13.%) calculated for September 2017, however, but no rate specific to site or type of infection, for example urinary tract, eye, respiratory or gastro-intestinal. Additionally under the September tab were four "infection Surveillance Worksheets" which corresponded to line items on the report, and contained the same information. There was no additional information or other reports or analysis regarding infections in September 2017.

August 2017:
A Monthly Line Listing Report/Monthly Healthcare Associated Infection Incident Rate worksheet was filled with twenty-one (21) infection line listings. No monthly infection rate was calculated for August 2017. Under the August tab were sixteen (16) "Infection Surveillance Worksheets" which corresponded to line items on the report. In addition, there was a final urine culture report among the collected worksheets for August 2017. There was no additional information or other reports or analyses regarding infections in September 2017.

There were no surveillance worksheets or monthly line listings under tabs from January through May 2017. There were individual infection worksheets for June and July, but there was no documented line listing to track infection along with no analysis of infections completed during these months.

During interview on 10/3/17 at 1:56 p.m., (ADON)-C stated she was now responsible for the infection control program (ICP) and was still

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working on the September infection percentages and infection rate. ADON-C stated since last winter there were a number of changes at the director of nursing position, and each time the director left, the responsibility for the ICP was passed from one to another, and did not get done. ADON-C stated the ICP was formally given to me in August of 2107, "it was just handed to me" and stated she still had questions and needed further education regarding how to run the ICP. ADON-C acknowledged current gaps in the monthly data, and lack of the current ICP, but stated going forward, there would be tracking and analysis, and review of the findings would be addressed during the monthly QAPI.

A facility policy, "Infection Prevention and Control Program, revised January 2017, indicated the goal of the program "is to identify and reduce risks of acquiring and transmitting infections among residents, employees, contract service workers, volunteers, students and visitors. The policy indicated "A coordinated process is established to reduce the risks of endemic and epidemic Healthcare Associated Infections in residents and HCWs. (health care workers). The policy indicated the process included prevention and surveillance control, and included tasks to document all resident infections; record infections on monthly line listing report; and present monthly line listing report to the Quality Assurance Performance Improvement (QAPI) committee.

WATER MANAGEMENT POLICY:

When interviewed on 10/3/17 at 2:298 p.m., the assitant director of nursing (ADON)-C istated she was not aware of any program begun in regard to

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a water management for the prevention of Legionnaire's disease. ADON-C stated she was aware of and had briefly looked at the CDC tool kit.

When interviewed on 10/4/17 at 1:29 p.m., the director or maintenance, (M)-A stated one of the regional directors of the facility had contacted him to set up a meeting to talk about the water management plan. The M-A mentioned a local company would coming to help the facility begin assessment of the water system as part of the water management plan. The M-A stated he was aware of the need to have a water management plan in place because, of "this Legionella" but stated we do not have policy in place right now. The M-A stated he had the (CDC) "toolkit" on his computer, but nothing down on paper.

When interviewed on 10/5/17 at 2:26 p.m. the assistant executive director, AED-A stated currently she had a date scheduled for a local company to begin testing in regard to the water management plan. The AED-A stated when had the CDC toolkit, and the facilty would be conducting a facility-wide assessment. The AED-A stated so far, that was what had been done in regards to creating a water management policy to address the Legionnaire's concern.

The facility provided no water management policy or procedure to address the potential of Legionnaire's disease in the facility.

LACK OF GLUCOMETER CLEANING:

An Assure Platinum Blood Glucose Monitoring System Quality Assurance / Quality Control Reference Manual dated 12/14, identified a

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frequently asked questions (FAQ) section under its cleaning procedures which dictated, "Blood glucose meters are at high risk of becoming contaminated with blood borne pathogens such as Hepatitis B Virus [HBV], Hepatitis C Virus [HCV], and Human Immunodeficiency Virus [HIV]. Transmission of these viruses from resident to resident has been documented due to contaminated blood glucose devices. According to the Centers for Disease Control and Prevention, cleaning and disinfecting of meters between resident use can prevent the transmission of these viruses through indirect contact." Further, the manual directed staff to clean the meter after each use with an EPA (Environmental Protection Agency) registered disinfectant or a solution of 1:10 concentration of bleach.

During observation on 10/4/17, at 6:54 a.m. licensed practical nurse (LPN)-D removed a community used Assure Platinum glucometer from a mobile medication cart on the first floor. The device was wrapped in a dried white cloth and seated in a green colored, handled container with unused lancets, device strips and alcohol wipes. LPN-D removed the dried white cloth and brought the device to R31's room. LPN-D pierced R31's skin using gloved hands, and obtained a sample of blood using the glucometer. Afterwards, LPN-D brought the device out of R31's room, placed it back on the medication cart and began to prepare R31's insulin for administration. LPN-D did not clean the glucometer with any wipes or chemicals after using it. At 7:43 a.m. LPN-D picked up the unclean glucometer and stated she was, "going to do the other blood sugar," and began to walk away from the medication cart, and into R89's room, with the device in her hand before being

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stopped by the surveyor.

When interviewed immediately following, LPN-D stated staff clean the device at night and it was, "supposed to be cleaned in between people," using a wipe which killed bacteria and viruses. LPN-D then cleaned the device using a designated wipe and stated it was important to clean it for, "contamination," purposes.

A provided, undated 1st Floor Gluc(ometer) (checks) listing identified eight different residents had current glucometer checks ordered on the first floor of the facility.

During interview on 10/4/17, at 12:34 p.m. assistant director of nursing (ADON)-A stated the glucometer(s) needed to be cleaned inbetween each resident, "for infection control issues," in case blood or bodily fluid had been transferred onto the device. Further, ADON-A stated nursing staff had just received education on this subject recently.

A facility Equipment - Cleaning/Disinfecting/Sterilizing policy dated 1/2017, identified the facility, "...will take action to prevent resident care equipment and supplies from becoming sources of infection," and all used equipment, "will be cleaned and disinfected as applicable before use with another resident." The policy listed three categories, including critical, semi-critical and noncritical, and listed examples underneath of each while directing these items, "will be cleaned, disinfected and sterilized according to manufacturer recommendation and CDC guidelines." The policy did not specifically identify their process for cleaning and disinfecting a community glucometer.

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| 21390 | Continued From page 156<br><br>APPROPRIATE INFECTION CONTROL TECHNIQUE DURING DRESSING CHANGE:<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue). Physician's dated 8/30/17, directed staff to, "Cleanse wound, pat dry, Flagyl (antibiotic medication) 250 mg (Milligrams) tab (tablet) crushed into wound, wet to moist [wound pack] using Dakins Solution (liquid wound cleanser) BID (two times daily).<br><br>During observation on 10/2/17 at 12:24 p.m., licensed practical nurse (LPN)-C completed a dressing change to R121's wound. Nursing assistant (NA)-A and NA-W helped to hold and maintain R121's position on the bed during the removal and placement of the wound dressing. Prior to the dressing change, LPN-C prepared the bed side table in R121's room and gathered needed supplies, among which included sterile, unopened 4" (inch) x (by) 4" gauze squares, and Dakins Solution (or DK solution, a type of solution made form diluted bleach, treated to reduce irritation, and is an antiseptic that kills most forms of bacteria and viruses). LPN-C removed and discarded the outer bandage and the packed gauze dressing presently in R121's wound, and then cleansed the wound and surrounding skin. After washing hands and donning new gloves, LPN-C grasped a new, unopened 4" x 4" gauze dressing package. LPN-C opened the package by ripping a 3/4" strip off across the top of the package, and with the gloved hand, removed the gauze, and placed the empty package wrapper | 21390 | | |

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on top of the bed side table. Next, LPN-C placed the gauze 4 x 4 she just removed on top of the empty package wrapper, then poured about 30 ml (milliliters) of DK solution on the gauze. The gauze was soaking on top of the gauze package wrapper, all on top of the bed side table. LPN-C then grasped the soaked gauze, and lightly squeezed out excess DK solution. Then, along with the crushed medication, LPN-C repacked R121's wound with the solution-saturated gauze. LPN-C placed a top bandage on R121's wound pack, and the dressing change was completed.

When interviewed on 10/2/17 at 1:06 p.m. LPN-C explained R121's dressing change. LPN-C stated she opened the gauze package, removed the gauze 4 x 4, placed it on top of the wrapper (on the outside of its package), then poured the DK solution into the gauze. LPN-C stated the gauze, soaked with the DK solution, along with the crushed Flagyl was ordered to be packed into R121's wound. LPN-C did not question the procedure stated she considered this be be a "clean" and not "sterile technique" for the changing of R121's wound dressing.

During observation on 10/3/17 at 11:06 a.m., registered nurse (RN)-B completed a dressing change for R121's wound. NA-B and NA-D helped hold and maintain R121's position on the bed during procedure. Prior to R121's treatment, RN-B washed his hands, cleaned the bedside table, then gathered supplies, medications and placed them on the table. Next, RN-B donned large gloves, which he struggled to put on. With gloved hands, RN-B removed the outer dressing, the packed, gauze dressing from R121's wound, and folded the wound packing into the gloves while he removed the gloves, then placed the bandages and gloves in the trash. Without first

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| 21390 | Continued From page 158<br><br>washing or cleansing his hands, RN-B donned another pair of gloves, grasped a new gauze 4 x 4 package, and ripped a strip across the top of the package to open it, and with the gloved hand, removed the gauze. With the gauze in his hand, RN-B began to wipe around the outside of R121's wound, folding the gauze in half and making a second wipe around the wound edges. RN-B again folded his gloves and disposed of the gauze and soiled gloves. RN-B donned another pair of gloves, without washing or sanitize his hands, opened another package of 4 x 4 gauze. RN-B then grasped hold of a liquid spray bottle and announced this was a "liquid wound cleanser" and began to spray R121's wound, both inside and out. Immediately the spray mixed with exudate from the wound, then drained and cascaded down out of the wound, as well from the surrounding skin dripping onto the towel and bed linen. With the gauze in hand, RN-B began to blot R121's wound, soaking up the dripping liquid and wound drainage. While cleansing the wound, the spray bottle came in contact with exudate that had cascaded down onto the towel and bedding on R121's bed; the bottle was visibly damp. RN-B removed his soilded gloves and disposed the soiled gauze by folding the gloves onto it, before final disposal into the trash. Before repacking R121's wound, RN-B removed and donned another pair of gloves, tore open an new gauze 4x4, and packed R121's wound. RN-B applied a top bandage to cover the packed wound, and completed the treatment.<br><br>When interviewed on 10/3/17 at 4:32 p.m. RN-B stated during the dressing change he tried to maintain clean technique, and thought he struggled mostly to open the gauze packages. RN-B stated he was not aware the outside of the spray cleanser bottle came in contact with the | 21390 | | |

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drainage from cleansing R121's wound. RN-B stated he thought the dressing change didn't go "too bad." RN-B did state he washed his hands, but only after the entire dressing change was completed.

When interviewed on 10/4/17 at 9:01 a.m., the assistant director of nursing (ADON)-C stated when opening a dressing package, like gauze, she would expect the package to be opened so as to expose the inside of the package, then pour the solution on top of that. ADON-C stated the outside wrapper was considered contaminated, "its filthy" ADON-C also stated it was important for staff to follow appropriate hand washing technique during dressing changes, and added "more education" regarding infection control was needed for the nurses. ADON-C stated this issue was very concerning because we have other residents with significant wounds.

A facility policy, Handwashing, dated January 2017, indicated Handwashing is the most important procedure for preventing healthcare acquired infections. The policy directed when staff was to wash hands, and indicated immediately after removing gloves. The policy required staff to use hand hygiene to remove dirt, organic material and transient microorganisms.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could review/revise policies for infection control survelliance, infection control practices with wound dressing changes, use of glucometers and educate all staff on these policies. Also, the director of nursing and/or designee could develop policies for Legionella. The DON and /or designee could educate all responsible staff on

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| 21390 | Continued From page 160<br>these policies and conduct audits of infection control practices for wound dressing changes, use of glucometers. In addition, the DON and/or designee could conduct audits of facility survelliance and implementation of Legionella policies to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: One (1) day. | 21390 | | |
| 21540 | MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring<br><br>Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.<br><br>This MN Requirement is not met as evidenced by: | 21540 | | 11/13/17 |

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| 21540 | Continued From page 161<br>Based on interview and document review, the facility failed to record indications for use with as needed (PRN) antipsychotic medication to ensure appropriate monitoring for 1 of 5 residents (R6) reviewed for unnecessary medication use.<br><br>Findings include:<br><br>R6's quarterly Minimum Data Set (MDS) dated 8/11/17, identified R6 had intact cognition, required extensive assistance with activities of daily living (ADLs) and displayed rejection of care and verbal symptoms on a less than daily basis.<br><br>R6's most recent signed physician orders dated 9/6/17, listed R6's current medications including order(s) for:<br>- Zoloft (an antidepressant medication) 200 mg (milligrams) by mouth every bedtime for depression;<br>- Risperdal (an antipsychotic medication) 3 mg by mouth every bedtime for a listed diagnosis of, "anxiety" and;<br>- Risperdal 0.5 mg, "by mouth twice daily as needed for depression." The PRN dosing had a listed start date of 6/14/17.<br><br>R6's medication administration record(s) (MAR) were reviewed. In August 2017, R6 did not take any of the PRN Risperdal. In September 2017, R6 received the PRN Risperdal once on 9/16/17, twice on 9/17/17, once on 9/21/17, and once on 9/27/17, for a total of five administrations. On the back side of the MAR, a column listing was labeled, "Comments/Nursing Observations," and provided directions for staff to identify why any medications had been withheld and, "When PRN medications are given, explain in Nurse's Medication Notes." However, the entire column section was left blank and uncompleted. | 21540 | Corrected | |

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R6's Psychiatric Progress Note dated 9/21/17, identified R6 had a history of schizoaffective disorder, bipolar type with staff reporting him to be, "seemingly stable and doing well overall." R6 was documented as having, "more difficulty keeping positive," due to poor wound healing, however, listed an assessment section with, "There have been no concerns reported by nursing staff." Further, dictation is listed of, "Of note, it does appear that he has been asking for his Risperdal p.r.n. on a few occasions since this provider reminded him that this is available to him if needed to target depression, anxiety, or unclear thinking."

R6's Behavior Chart Detail Report dated 8/5/17 to 10/3/17, identified R6 had no recorded behaviors on the dates the PRN Risperdal was provided. Further, R6's progress note(s) dated 8/5/17 to 10/3/17, lacked any recorded indications or rationale for the PRN Risperdal being provided.

When interviewed on 10/4/17, at 9:32 a.m. nursing assistant (NA)-G stated R6 was particular in how staff cared for him and, "very non-compliant," at times with thinking staff didn't have equipment to help him, so he would refuse cares. NA-G stated she was unaware of R6 having any hallucinations or other delusional thinking, and further stated any behaviors R6 displayed would be reported to the nurses and charted.

During interview on 10/5/17, at 8:10 a.m. licensed practical nurse (LPN)-F stated R6 received the PRN Risperdal for depression and sometimes would ask for it when screaming or yelling at the staff. LPN-F stated the usual facility practice was for R6's progress notes, or the back side of the

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MAR, to have documentation to support why the PRN Risperdal had been given in September. However; after reviewing R6's record with the surveyor added it was not and, "its supposed to be there."

On 10/5/17, at 8:41 a.m. registered nurse (RN)-A and assistant director of nursing (ADON)-A were interviewed. ADON-A stated staff should be documenting, "the indication," for giving as needed medication on the back side of the MAR or in the progress notes. ADON-A stated it was important to document rationale for giving as needed medication, "so you can determine the effectiveness of the medication," and to ensure, "it was necessary."

Although R6 had orders for PRN Risperdal, the staff failed to document the reasoning and indication when they administered it to allow periodic assessment and evaluation to determine if the medication was being effective and/or still warranted.

A facility Psychoactive Medication policy dated 1/2016, directed staff to document, "PRN medication use as applicable," on the care plan and CareTracker system, and staff would completed a review of psychoactive medication use when applicable and during the RAI (Resident Assessment Instrument) process.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could review/revise policies regarding monitoring of psychotropic medications for ongoing justification for the use of those medications. The DON and/or designee could educate licensed staff on these policies and conduct audits of psychotropic medication use to ensure ongoing justification for

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| 21540 | Continued From page 164<br>the use of psychotropic medications.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21540 | | |
| 21565 | MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin<br><br>Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess for the safety of self administration of medications for 1 of 1 resident (R48) who was observed to have medications at bedside and also self administered oral medications.<br><br>Findings include:<br><br>R48's quarterly Minimum Data Set dated 6/17/17, indicated R48 was cognitively intact.<br><br>During observation on 10/1/17, at 9:57 a.m. R48 had a bottle of nitroglycerin 0.4 milligrams (mg) on her bedside table.<br><br>R48's Self- Medication Data Collection and Assessment dated 1/10/17, indicated nursing was to administer all medications as the resident was unable to safely self- administer medication.<br><br>R48's physician order dated 7/11/17, indicated it | 21565 | Corrected | 11/13/17 |

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was okay to leave R48's nitroglycerin (medication to treat chest pain) at the bedside. However, nursing failed to complete an assessment to ensure R48 was safe to administer the nitroglycerin on her own.

During observation on 10/1/17, at 10:19 a.m. registered nurse (RN)-E handed R48 her morning medications in a clear cup and left the room. R48 poured the pills onto her bedside table and proceeded to check to make sure what medications were there before self-administrating them. The bottle of nitroglycerin was also noted on the bedside table.

During interview on 10/3/17, at 10:20 a.m. RN-E stated she did not stay to observe R48 take her medications because it was "alright" to leave them at the bedside and indicated it was because she was a hospice patient.

On 10/3/17, at 10:22 a.m. RN-A stated medications could be left at a resident's bedside if there was a nursing assessment completed and a physician's order to do so. After reviewing R48's chart, RN-A stated R48 did not have a current assessment indicating R48 was safe to have nitroglycerin at the bedside or for nurses to leave medications for her to self administer after set-up.

During follow- up interview on 10/3/17, at 10:48 a.m. RN-E stated the medications that had been left at R48's bedside to self administer were: omeprazole (treatment of gastroesophageal reflux disease) 40 mg, ativan (anti-anxiety) 0.5 mg, morphine sulfate (narcotic) 15 mg, two tablets of Tylenol (pain reliever) 500 mg, two capsules of diltiazem (treat high blood pressure, angina and certain heart rhythm disorders) 180 mg, duloxetine (treat major depressive disorder, )

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| 21565 | Continued From page 166<br>60 mg, and two capsules of gabapentin (treat nerve pain) 400 mg.<br><br>A facility policy on self- administration of medications was requested and was not received.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies for resident self administration of medication, and educate the responsible licensed staff on those policies. The DON and/or designee could conduct audits of medication administration for residents to ensure residents who self administer are safe to do so.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21565 | | |
| 21580 | MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements<br><br>Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure insulin was administered in accordance with manufacturer instructions to ensure complete dosing for 1 of 1 | 21580 | Corrected | 11/13/17 |

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residents (R31) observed to receive insulin. In addition, the facility failed to ensure opened insulin's were dated when opened to prevent potential administration after expiration for 2 of 2 residents (R200, R84) observed to have undated insulin available for administration in the medication cart(s).

Findings include:

INSULIN ADMINISTRATION:

R31's signed physician orders dated 9/25/17, identified an order for a Lantus Solostar Pen (long acting insulin used to reduce blood sugar levels) and directed staff to, "Inject 71 units [subcutaneous; under the skin] twice daily," for management of his diabetes (disease causing increased blood sugar levels).

A BD (Becton, Dickson and Company) Autoshield Duo Safety Pen Needle Instructions for Use insert dated 6/2014, identified instructions for how to attach the needle to an insulin pen. The instructions directed to screw the needle onto the pen, remove the cover and then, "Check if the Pen Needle is attached correctly - dial 2 units, point the pen up and press the thumb button." Further, the instructions identified to repeat if liquid does not appear at the needle tip.

During observation of insulin administration on 10/4/17, at 6:54 a.m. licensed practical nurse (LPN)-D removed a Lantus insulin pen from a mobile cart on the first floor. The pen was undated when it had been opened and first used, and LPN-D stated it was, "a good question," however, added R31 used it quickly due to a high dose. LPN-D removed a BD Pen Needle and attached it to the device, then turned the dial

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(used to determine the dose) up to 71 units and showed the surveyor. LPN-D then closed R31's medication administration record (MAR) and began to walk over to R31 to administer the medication. LPN-D was stopped by the surveyor and questioned about if the insulin pen had been primed. LPN-D stated, "you do not prime," the needle with insulin before administration as the needle was considered sterile. LPN-D then administered the insulin using the pen with an un-primed needle to R31 in his room.

Immediately following the administration, LPN-D was interviewed and stated she felt there was no need to prime the needle before insulin administration, as there was no air inside the insulin pen. LPN-D reviewed the safety needle instructions including priming of the needle with the surveyor, and stated, "that's what I did."

When interviewed on 10/4/17, at 11:23 a.m. assistant director of nursing (ADON)-A stated insulin pen needles should be primed before being used to remove air from the needle to, "make sure they're [residents] getting the correct dosage."

During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated a needle attached to an insulin pen should be primed with a, "two unit air shot," before being used on a patient.

A facility Insulin Injection policy dated 7/2015, identified a subject to safely administer insulin and listed a procedure for staff to follow using an insulin vial with syringe, however, lacked any directions or procedures for staff to use when injecting insulin using a flexpen and attached needle.

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LACK OF INSULIN DATING:

On 10/1/17, at 10:50 a.m. the Second Floor South medication cart was reviewed with licensed practical nurse (LPN)-H. The top drawer of the cart was opened with four opened, uncapped vials of insulin inside. One vial of Novolin R (short acting insulin, good for only 42 days after being opened) was approximately 3/4 full, however, lacked any labeling to identify which resident had been using it, or when it was opened. Further, an additional vial of Novolog (short acting insulin) was approximately 1/2 full and had no label or writing on the vial to demonstrate when it had been opened or which resident was using it. LPN-H reviewed both vials and stated she was unaware how long they had been opened for, nor which resident received them adding, "these can just be tossed."

A vial of Novolin N (an intermediate acting insulin) was labeled for R200 with approximately 1/2 of the insulin remaining inside. The label had spacing on a yellow colored sticker to record the, "date opened," and, "exp. [expiration] date," however, both of these spaces were left blank. There was no recorded, visible date on the vial to identify when it had been opened. LPN-H stated she was, "not sure," when they were opened. In addition, two separate opened Lantus flexpen(s) were stored in the cart and also labeled for R200. LPN-H observed the pens and stated, "nothings labeled," when they were opened.

Further, two additional separate Lantus flexpens were inside and labeled for R84. One of the pens was dated when it had been opened, however, the other was undated and lacked any markings

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to demonstrate when it had been removed from the refrigerate and opened. LPN-H stated it, "need to be thrown," and staff should be recording dates on all insulin when they are opened as, "they expire in a month."

When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated insulin, "needs to be dated," when opened as insulin expired after a set period of time.

During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated insulin containers should be dated when opened to follow recommended storage guidelines and so staff, "know how long their good for."

A facility Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy dated 10/16, directed staff to follow manufacturer/supplier guidelines for expiration dates for opened medications including to, " ... record the date opened on the medication container when the medication has a shortened expiration date once opened."

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could review/revise policies for storage of medications, expiration of medications, and educate all responsible licensed staff on those policies. The DON and/or designee could conduct audits of resident medications, storage of those medications, to ensure that date vials of medications (such as insulin) are opened, and to provide medications according to manufacturer recommendations when using of insulin pens is done consistently.

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| 21580 | Continued From page 171<br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 21580 | | |
| 21630 | MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction<br><br>Subp. 2. Destruction of medications.<br>A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years.<br>B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure transdermal narcotic patches were disposed of in methods to help prevent diversion. This practice had potential to | 21630 | Corrected | 11/13/17 |

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affect 2 of 2 residents (R188, R161) with current orders for transdermal patches in the facility. Further, the facility failed to ensure narcotic reconciliation was completed in accordance with policies and procedures to ensure rapid detection of potential diversion on 3 of 3 medication carts (4th Floor, 3rd Floor, 2nd Floor) reviewed during the survey. This had potential to affect 38 of 38 residents with current orders for controlled substances on these affected floors.

Findings include:

A facility Destruction of Controlled Drugs policy dated 7/2015, directed staff to destroy used transdermal patches (i.e. Fentanyl [a potent narcotic medication]) following removal from a resident with, "Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record [MAR]." Further, the policy identified flushing transdermal patches was the, "preferred," method unless it was prohibited, then staff should be cutting the patches in half and placing them into a, "drug buster" system.

An undated Fentanyl Patch listing was provided which identified R188 and R161 had current orders for Fentanyl transdermal patches in the facility.

On 10/1/17, at 10:50 a.m. the Second Floor South medication cart was reviewed with licensed practical nurse (LPN)-H. The cart contained a second metal container with was locked with a key. The container was opened and several narcotic medications were housed inside including several opened boxes of Fentanyl transdermal patches. LPN-H described the process for removing and disposing of used

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transdermal patches, stating staff were supposed to, "have somebody watch," when used patches are removed and disposed of. LPN-H stated when she removed patches, she placed them, "in the sharps container [attached to medication cart, able to be accessed using scissors and cutting]." Further, LPN-H stated she had changed a patch for R188 that morning (10/1/17), however, added she did not have anyone else watch it as nobody was available at the time.

R188's 10/2017 MAR was reviewed with LPN-H. The MAR identified an order for Fentanyl 50 mcg/hr (micrograms per hour) to be applied every 72 hours. Further, the MAR had directions of, "Fold and flush patch down toilet following removal / Two nurses must witness," and provided spacing for two nurses to record their initials when completed. However, these spaces were left blank with no initials recorded.

When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated used transdermal patches should be removed with two nurses present and disposed to, "via sewer." ADON-A stated removing patches without two staff and disposing of them in a sharps container was, "not acceptable," and the nurse, "needs education."

During interview on 10/5/17, at 12:07 p.m. consulting pharmacist (CP)-A stated the facility policy was for two nurses to witness and destroy the used transdermal patches via sewer as there was, "left over drug on the patch." CP-A stated the nurse disposing of the patch in the sharps container and removing on her own, "didn't follow the policy."

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NARCOTIC RECONCILIATION:

A facility Controlled Drugs policy dated 7/2016, identified a directive to, "assure that all Centers have procedures in place to safeguard the ordering, receipt, administration, storage and destruction of controlled drugs." The policy outlined a section of, "Ongoing Inventory of Controlled Drugs at Each Shift ...," and directed staff to document all controlled medications, including schedule II, III, IV, and V, had been counted by the off-going and on-coming nurse or trained medication aide (TMA).

Further, an additional Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy dated 10/16, identified a section labeled, "Controlled Substances Storage," and directed, "Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security."

On 10/1/17, at 9:49 a.m. the South 4th Floor medication cart was reviewed with licensed practical nurse (LPN)-G. The cart was locked with a physical key with an additional metal compartment inside which contained oral narcotic medications. LPN-G opened the locked metallic compartment and stated she, "[had] not signed out a few," of the narcotics she gave this morning during her 8 a.m. medication pass. LPN-G would not complete a narcotic count with the surveyor before signing them out. When completed, LPN-G and the surveyor counted the narcotics inside the metallic compartment. LPN-G stated R123 should have 59 remaining oxycodone pills aloud, however, one had been removed from the middle of the package and only 58 pills remained. LPN-G stated she, "did not notice that," when counting with the off-going nurse that morning

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and added, "I don't know what happened." No further narcotic counts were incorrect on the medication cart. LPN-G reviewed for process for counting the medication carts with the surveyor, and stated the nurses sign off each time they count on a flowsheet contained in a binder. These flowsheets consisted of six columns with each nurse signing off for each shift. A total of six signatures were required to satisfy the flowsheet and provide evidence the medication cart had been counted. The following was identified:

September 2017:
9/1/17 - three of the six spaces were left blank,
9/2/17 - all six spaces were left blank,
9/3/17 - all six spaces were left blank,
9/4/17 - five of the six spaces were left blank,
9/5/17 - one of the six spaces were left blank,
9/8/17 - two of the six spaces were left blank,
9/10/17 - three of the six spaces were left blank,
9/11/17 - all six spaced were left blank,
9/12/17 - all six spaces were left blank,
9/13/17 - three of the six spaces were left blank,
9/14/17 - two of the six spaces were left blank,
9/15/17 - three of the six spaces were left blank,
9/16/17 - all six spaces were left blank,
9/17/17 - five of the six spaces were left blank,
9/18/17 - two of the six spaces were left blank,
9/19/17 - two of the six spaces were left blank,
9/20/17 - two of the six spaces were left blank,
9/21/17 - four of the six spaces were left blank,
9/23/17 - one of the six spaces was left blank,
9/24/17 - three of the six spaces were left blank,
9/25/17 - one of the six spaces was left blank,
9/26/17 - three of the six spaces were left blank,
9/28/17 - three of the six spaces were left blank,
9/29/17 - three of the six spaces were left blank and;
9/30/17 - two of the six spaces were left blank.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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In total, the cart had five instances when the cart had not been documented as being counted for an entire day. When interviewed immediately following this review, LPN-G stated she was unsure if the cart had not been counted, or if it had just not been documented adding, "it is not right." LPN-G stated it was important to count the medication carts each shift as, "medication might be missing."

The narcotic count flowsheets were provided for the remaining medication cart(s) on the 4th Floor and identified the following:

4th Floor "Middle" for September 2017:
9/1/17 - two of the six spaces were left blank,
9/3/17 - two of the six spaces were left blank,
9/4/17 - two of the six spaces were left blank,
9/5/17 - two of the six spaces were left blank,
9/10/17 - three of the six spaces were left blank,
9/11/17 - three of the six spaces were left blank,
9/13/17 - two of the six spaces were left blank,
9/17/17 - two of the six spaces were left blank,
9/18/17 - two of the six spaces were left blank,
9/21/17 - two of the six spaces were left blank,
9/22/17 - two of the six spaces were left blank,
9/26/17 - five of the six spaces were left blank,
9/27/17 - three of the six spaces were left blank,
9/28/17 - three of the six spaces were left blank,
9/29/17 - three of the six spaces were left blank and;
9/30/17 - one of the six spaces was left blank.

4th Floor "North" for September 2017:
9/1/17 - one of the six spaces was left blank,
9/2/17 - four of the six spaces were left blank,
9/3/17 - four of the six spaces were left blank,
9/4/17 - one of the six spaces was left blank,
9/5/17 - three of the six spaces were left blank,
9/6/17 - three of the six spaces were left blank,

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9/7/17 - five of the six spaces were left blank,
9/8/17 - three of the six spaces were left blank,
9/9/17 - two of the six spaces were left blank,
9/10/17 - five of the six spaces were left blank,
9/11/17 - three of the six spaces were left blank,
9/12/17 - all six spaces were left blank,
9/13/17 - three of the six spaces were left blank,
9/14/17 - two of the six spaces were left blank,
9/15/17 - five of the six spaces were left blank,
9/16/17 - three of the six spaces were left blank,
9/17/17 - two of the six spaces were left blank,
9/19/17 - two of the six spaces were left blank,
9/21/17 - four of the six spaces were left blank,
9/23/17 - three of the six spaces were left blank,
9/24/17 - three of the six spaces were left blank,
9/25/17 - one of the six spaces was left blank,
9/26/17 - two of the six spaces were left blank,
9/27/17 - two of the six spaces were left blank,
9/28/17 - five of the six spaces were left blank,
9/29/17 - five of the six spaces were left blank and;
9/30/17 - three of the six spaces were left blank.

On 10/1/17, at 10:33 a.m. the 3rd Floor South medication cart was reviewed with LPN-B who reviewed the process for counting and reconciling narcotic medications. LPN-B stated narcotics were counted, "during shift change," and recorded on flowsheets kept in a binder. These flowsheets were reviewed and consisted of the same format used on the 4th Floor cart(s) and identified the following:

September 2017:
9/2/17 - one of six spaces was left blank,
9/3/17 - one of six spaces was left blank,
9/9/17 - one of six spaces was left blank,
9/17/17 - one of six spaces was left blank,
9/18/17 - one of six spaces was left blank,
9/19/17 - one of six spaces was left blank,

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9/22/17 - one of six spaces was left blank,
9/23/17 - one of six spaces was left blank,
9/24/17 - one of six spaces was left blank,
9/27/17 - one of six spaces was left blank and;
9/29/17 - one of six spaces was left blank.

When interviewed immediately following this review, LPN-B stated staff must had, "forgot to sign off," on the counts being completed adding, "they [open spaces] should be filled in." LPN-B stated it was important to count and document the narcotic count each shift as, "that's how we know the count is correct," and nothing was missing. Further, LPN-B and the surveyor completed a count of the narcotics in the medication cart and found it to be correct.

On 10/1/17, at 10:50 a.m. the 2nd Floor South medication cart was reviewed with LPN-H who reviewed the process for counting and reconciling narcotic medications. LPN-H stated the narcotics were counted between each shift exchange, and both nurses were to sign the narcotic counting flowsheets contained in a binder on the cart. These flowsheets were provided and identified the following:

September 2017:
9/2/17 - one of the six spaced were left blank,
9/3/17 - four of the six spaces were left blank,
9/4/17 - two of the six spaces were left blank,
9/5/17 - one of the six spaces was left blank,
9/8/17 - two of the six spaces were left blank,
9/9/17 - one of the six spaces was left blank,
9/17/17 - two of the six spaces were left blank,
9/18/17 - two of the six spaces were left blank,
9/19/19 - one of the six spaces was left blank,
9/21/17 - one of the six spaces was left blank,
9/22/17 - two of the six spaces were left blank
9/23/17 - three of the six spaces were left blank

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and;
9/26/17 - one of the six spaces was left blank.

When interviewed immediately following this review, LPN-H stated she was unsure why nurses had not signed the flowsheet to demonstrate they had counted the narcotics adding, "people maybe forgot to sign." Further, LPN-H stated it was important to count and sign the flowsheet as nurses coming on are, "taking credit the count is right," and so it could be tracked who had access to the medications inside.

The narcotic count flowsheets were provided for the remaining medication cart(s) on the 2nd Floor and identified the following:

2nd Floor "North Cart" for September 2017:
9/2/17 - one of the six spaces was left blank,
9/5/17 - one of the six spaces was left blank,
9/6/17 - one of the six spaces was left blank,
9/7/17 - one of the six spaces was left blank,
9/8/17 - two of the six spaces were left blank,
9/9/17 - one of the six spaces was left blank,
9/10/17 - one of the six spaces was left blank,
9/11/17 - five of the six spaces were left blank,
9/12/17 - four of the six spaces were left blank,
9/13/17 - two of the six spaces were left blank,
9/14/17 - three of the six spaces were left blank,
9/19/17 - one of the six spaces were left blank,
9/20/17 - one of the six spaces were left blank,
9/21/17 - five of the six spaces were left blank,
9/22/17 - two of the six spaces were left blank,
9/23/17 - one of the six spaces was left blank,
9/29/17 - one of the six spaces was left blank
and;
9/30/17 - two of the six spaces were left blank.

A facility provided Month End Operations Report dated 10/4/17, identified 38 different residents

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had controlled substances stored amongst the three reviewed medication carts.

When interviewed on 10/4/17, at 11:30 a.m. assistant director of nursing (ADON)-A stated the medication cart narcotics should be counted between each shift and documented on the flowsheet(s) so, "you know which nurse is responsible for the narcotics should anything go missing."

During interview on 10/5/17, at 12:07 p.m. the consulting pharmacist (CP)-A stated she completes audits on the medication carts, "periodically," and noticed back in June 2017, the narcotic counts were not being signed consistently. CP-A stated on her most recent audit, which had been completed less than a month ago, she again noticed "isolated issues" with the narcotic counts not being recorded. CP-A stated her audit results were reviewed with the interim director of nursing (DON) at the time, and also placed in a report for the facility on their website, however, added it was the facility's responsibility to review them. Further, CP-A stated staff should, "follow procedures" and ensure they are documenting each narcotic count.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could develop and/or revise policies on the proper destruction of unsed medications, including fentanyl patches removed from residents for whom they were prescribed. The DON and or designee could educate staff on those policies and conduct audits of destructions practices in the facility to ensure proper destruction of unused

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| 21630 | Continued From page 181<br>medications, fentanyl patches are being consistently implemented.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21630 | | |
| 21665 | MN Rule 4658.1400 Physical Environment<br><br>A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interview and document review, the facility failed to manage facility odors in an acceptable manner on the 4th floor, affecting 2 residents (R84 and R2) residing in that room. A ceiling tile was missing in room 329, potentially affecting R113, electric outlets were not in safe working order, room tiles, and window were also not maintained in room 104, affecting R111. Wall mounted fans were not cleaned in room 106 affecting R66, and the 1st floor dining room's (DR) ceiling and wall mounted fans were not cleaned, affecting 13 resident whom ate their meal in the first floor DR.<br><br>Findings include:<br><br>During the environmental tour, held on 10/3/17 at 2:25 p.m., the following issues were reviewed with the facility staff - maintenance director (M)-A, maintenance technician (MT), corporate carpenter/engineer (CCE), contracted housekeeping director - Healthcare Service Group, Inc. (HSKP) and assistant executive | 21665 | Corrected | 11/13/17 |

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| 21665 | Continued From page 182<br>director (AED-A).<br><br>There was a strong, pungent urine odor in a resident room, where R82 and R2 resided. The smell lingered into the hallway, and was especially notable at the door into their room. Upon entering the room, R84 was observed sitting in a wheel chair (WC) looking out the window. R84's bed had only a fitted sheet with a soaker pad (pad used to absorb urine for resident that were incontinent), as well as, a vinyl recliner that also had a soaker pad. When approached, R84 had a strong pungent odor of concentrated urine emanating from his person. The floor of the room was sticky, causing surveyor and staff's footsteps to be heard.<br><br>HKSP stated that R84 will not wear any incontinent products, while he states they are for "women". The family has replaced R84's recliner 3 times in the last 2 years due to being saturated with urine. When asked about odor control, they try charcoal, cleaners and have this room and 5 other rooms on a "6 times a day - everyday cleaning schedule" but the odors still persists. When asked if they have tried a urea-neutralizing cleaners (used to breakdown urine salts and proteins), HSKP stated that they have not. AED-A then asked HSPK why this product has not been used, to which HSKP stated that type of product is not listed in their contract for use within this facility.<br><br>On 10/3/17 at 2:34 p.m., maintenance technician (MT) stated when issues are noted the floor staff, have been instructed to contact maintenance and housekeeping. If there is an issue(s) that needs immediate attention, MT indicated they can call on the walkie-talkies, or call on the phone. They can also leave written information at the nursing | 21665 | | |

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stations, which would be picked up when maintenance and housekeeping rounds through the building each day.

On 10/3/17 at 2:44 p.m., the bathroom in room 329 was reviewed. The bathroom had a suspended ceiling with 2 foot (ft) x 3 ft ceiling tiles. The area above the toilet was missing a section of ceiling tile, that was approximately 6 ft x 2 ft, with the middle support bar missing that would of been between the 2-3 ft sections. MT stated maintenance was unaware of the missing tiles and both housekeeping and/or floor staff should report this to the maintenance department.

At 2:57 p.m. in room 104-1 (first bed in room - R111), noted a 4-outlet electrical box just above the mopboard, that was pulled off the wall between the wall and residents bed, and was hanging at a 45 degree angle, with the wires intact. The outlet was being used to run R111's electric Hi-Lo bed. Neither M-A, MT or HSKP were aware of this issue. MT stated it appeared staff lowered the Hi-Lo bed onto the outlet box dislodging it from the wall. This would be repaired right away. The threshold between the bathroom and bedroom was cracked with tile missing measuring approximately 18 inches in length and 1 inch in width. A piece of title was missing in the room measuring approximately four inches by nine inches by four inches. The CCE, identified this would be repaired, and the area did not provide a transition from the room to the other. The bedroom window had missing weather stripping which allowed an opening to the environment approximately 1/2 inch wide by the entire length of the window. The CCE stated this would be corrected immediately.

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In Room 106 at 3:11 p.m., the oscillating wall fan next to the bathroom, had a heavy build up of gray dust, that occluded the fan cage. There were strings of dust (approximately 2-3 inches) blowing out from the fan cage. The blades of the fan also had a heavy buildup of dust and black debris on the edges. HSKP stated the fans should be cleaned on monthly basis.

In reviewing of the 1st floor dining room, at 3:24 p.m., a white ceiling fan, appeared gray with a heavy accumulation of gray dust. The on/off fan switch was broken off, and the fan could only be cleaned by turning the ceiling lights off. M-A stated they would have to fix the ceiling fan controls so that the housekeeping staff could clean the fan and fan blades. A oscillating wall fan, also located in the 1st Floor dining room, had a heavy build up with mats of gray dust on the fan cage. HSKP stated the housekeeper would not of been able to clean the ceiling fan, because it could not be turned off unless the light was off. She stated housekeeping should have noticed the wall fan, and should be cleaning this on a monthly basis. Licensed practical nurse (LPN)-B whom was in the dining room at this time, stated approximately 13 residents ate in the dining room.

In review of the facility policy, entitled: Maintenance and Repair: To Prevent Spread of Infection (revised January 2017), pertained more to "Personnel Health" (personal protection was to be used) and Preventative maintenance rather than what should be reported to maintenance / housekeeping for repairs . On page 3 of the same policy, in a section entitled: Pluming Supply and Drainage Systems , the policy indicated that the facility was to have "scheduled regular preventive maintenance for 7 systems, which included "sink

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fixtures" and the "water supply system."

The policy did not address electrical or ceiling tile issues.

A second facility maintenance policy, entitled: Physical Environment (effective July 2015), indicated that the facility "provides a safe, clean, comfortable, and home like environment for each resident..." and " all essential mechanical, electrical, and resident care equipment is maintained in safe operating condition through the center 'Preventative Maintenance Program'." The policy further indicated that the maintenance and housekeeping manager would be performing weekly rounds to include "resident rooms (10), common areas, offices, gym and laundry." This policy indicated that the facility would correct concerns found and keep results of the weekly rounds, providing them to quality assurance every 4 weeks.

Request for the last 3 months of weekly rounds, findings and completion records were requested, however wer not received.

Two separate policies were provided by HSKP, from Healthcare Services Group, Inc, - Housekeeping In-Service, both dated 1/1/2000. The first, entitled: Complete Room Cleaning, indicted the purpose of the policy was: "[insures] that each resident room is discharge-cleaned on a monthly basis. This policy made no mention of any of the concerns mentioned above. The second policy, entitled: 5-Step Daily Patient Room Cleaning, also did not mention what staff should do when noting missing ceiling tiles, dirt fans, fruit flies or other environmental concerns, only basis room cleaning.

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| 21665 | Continued From page 186<br>HSKP was asked for cleaning logs for the 6 rooms designated as "to be cleaned six times a day" and fan cleaning for the last 3 months. However, on 10/5/17 at 12:43 p.m., the AED-A stated that neither HSKP nor the facility had supporting documentation that these 6 rooms and the fans noted were being completed, as referred to during environmental tour by HSKP.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The administrator or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21665 | | |
| 21730 | MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure adequate pest control was maintained for flying insects throughout the facility, which was mainly identified | 21730 | Corrected | 11/13/17 |

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throughout the 1st floor and dining room. This deficient practice had the potential to affect all 95 residents (R31, R162, R130, R35) residing in the facility.

Findings include:

R31 was interviewed on 10/01/2017, at 9:53 a.m. stated the facility has problems with sewer flies, the water fountain doesn't work and it is rusted, and the unused bathroom tubs "I think the sewer flies come from there. The flies are everywhere." R31 further indicated a lot residents are coughing and hacking. R31 then stated " Last Monday I told administrator to do some thing about the fly problem, but I don't think anything was done about it". At 12:29 p.m. R31 stated "there are often sewer flies in the condiment trays, and if you twirl them around, they fly out."

During interview on 10/2/17, at 1:02 p.m., R31 stated there were sewer flies in the first floor dining room. When we are eating they really come out, and the flies came out of the dry drains and go to the food. At 12:02 p.m. licensed practical nurse (LPN)-E stated she had seen flies, but did not know where they came from.

During interview 10/01/17, at 10:06 a.m. R162 stated he had been at the facility for five months and the "This place sucks"! In addition R162 stated there is sewer flies in his room and the elevators.

During interview 10/01/2017, at 10:10 a.m. R130 stated he had been at the facility about a year. The food is cold I don't eat breakfast because its the same thing every day. In addition R130 stated he eat's in his room because of the bugs and there is lots of flies in the dinning room.

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During observation 10/02/2017, at 12:51 p.m. observed a small black fly over R35's lunch tray in her room. An additional observation was observed of a fly in R35's room flying over R35's completed lunch tray again at 12:59 p.m.

During an observation on 10/02/2017 at 1:25 p.m., multiple fly's were seen flying around the 1st floor dining room. At 1:42 p.m. four flies were noted on the garbage bag, and six flies on the kitchenette wall.

During observation of the 3rd floor conference room on 10/03/2017 at 8:08 a.m., multiple small fly's was noted flying around the room.

While performing record review at the 1st floor nursing station, on 10/3/17 from 8:41 a.m. - 11:28 a.m., several flies were observe flying around the nursing station and residents areas on the first floor.

During observation on 10/03/2017, at 8:43 a.m. and at 9:00 a.m. at the first floor nurses station small black fly was flying around the desk.

During environmental tour, on 10/3/17 at 2:25 p.m., maintenance director (M)-A stated that he was aware of the "flies" being in the 1st floor dining room which was continuing for the past two week. He stated they were "fruit flies." He had the housekeepers washing out all the garbage cans in this area, and making sure food is not left in the dining room, and thought the problem was resolved. When M-A tapped the sink on the kitchenette of the 1st floor dining room, small black flies emanated from the sink area. M-A stated he would call a pest control company that day.

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| 21730 | Continued From page 189<br><br>On 10/4/17 at 7:51 a.m., on a environmental tour with M-A and the contracted company's (Adam's Pest Control, Inc.) pest control technician (PCT), reviewed the facility "bug lights" wall sconces and the "glueboards" (sticky traps) placed inside of each light were inspected. The following was noted:<br><br>> On the 4th floor, the glueboard within the bug light, was noted to have trapped the following: approximately 5 house flies, one ground hornet, multiple black-eyed fruit flies and numerous fungus gnats. This light was located in the 4th floor dining area.<br>> On the 3rd floor bug light was located in the old dining area, now utilized a a open general storage area. The light's glueboard also had a three house flies, a two moths, a Eurasian beetle, multiple black-eyed fruit flies and a numerous of fungus gnats.<br>> On the 2nd floor dining area collected house flies, black-eyed fruit flies and fungus gnats. The bug light, located inside the delivery entrance of the kitchen on the 2nd floor, collected several house flies, multiple black-eyed fruit flies and fungus gnats. During the tour of the kitchen, PCT reached under the kitchen ice machine, and pulled from the floor drain, dark gray moist matter, with food debris.<br>> On the 1st floor dining room bug light glueboard, was found to have a number quantity of black-eyed fruit flies and fungus gnats.<br><br>During an interview 10/04/2017 9:10 a.m., PCT stated that black-eyed fruit fly / dark-eyed fruit flies, are much larger than regular fruit flies and are caused by collection of food /organic waste in high moisture locations, which can be controlled by thorough cleaning of breeding sites | 21730 | | |

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such as drain traps and garbage collection areas. PCT stated, like all flies, during the warmer months of the year, staff need to routinely clean these areas. PCT states areas such as drains (especially floor drains) may need to be power-washed, which included removing the floor drain grates and cleaning the undersides as well. The PCT suggested to M-A that all drains be flushed with 3-5 gallons of water, to assure the drains are free flowing, to help control all forms of fruit flies. PCT further suggested to M-A that all floor coverings (including vinyl and ceramic tiles) be inspected for cracks and potential areas that are dark and collect moisture. These areas need to be deep cleanse and disinfected. PCT stated that the fungus gnats, once it freezes outside should dramatically decrease in numbers, but as for the other flies (house, fruit and black-eyed fruit flies), warm moist dark areas will allow them to continue breeding throughout the winter. PCT denied the presence of "sewer flies" while the areas where they would breed, appear to be sealed and intact (no open sewer lines not missing caulking around toilets).

In review of the facility's policy, entitled: Pest / Insect Control (effective July 2015), the policy indicated: "The center strives to protect the residents, staff and visitors from insects and other pests by controlling infestations through contracts with outside pest control agencies." However, the policy did not indicated how they, as a facility, would attempt to control and prevent infestations on a routine basis (i.e.: containment of refuge, routinely monitoring and cleaning breeding areas, thoroughly cleaning / removal of organic matter - as suggested by the PCT).

SUGGESTED METHOD OF CORRECTION:
The administrator, maintenance supervisor, or

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| 21730 | Continued From page 191<br>designee could ensure a preventative pest control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21730 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure resident's clothing were donned and covered residents exposed skin for 1 of 5 residents (R10). In addition, the facility failed to ensure personal hygiene was maintained in a dignified manner for 2 of 5 residents (R55, R2) reviewed for dignity.<br><br>Findings include:<br><br>R10's Face Sheet indicated diagnoses of CVA (stroke), neuromuscular dysfunction of the bladder, and hemiplegia (weakness) of the left side due to CVA. A quarterly Minimum Data Set | 21805 | Corrected | 11/13/17 |

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(MDS) dated 9/14/17, indicated R10 was cognitively intact, and required extensive assistant of two staff for dressing and grooming.

During initial tour observations on 10/1/17, at 9:41 a.m. R10 was sitting in the entrance of the facility leaning to the right wearing a soiled smoking apron. The smoking apron hung to R10's right, and resident's shirt pulled up exposing his stomach and urostomy (device to collect urine, attached to the abdomen). At 10:03 a.m., R10 was observed to leave the facility to visit with a pastor, sitting outside, stomach and urostomy still exposed.

On 10/4/17, at 6:51 a.m. R10 was observed again sitting in the facility main entrance. R10 was facing the door. R10 was wearing a red polo shirt which was hiked up to just below his chest, with urostomy fully exposed. R10 stated it bothered him that his stomach and urostomy are exposed, but his clothes are tight. R10 further stated, when transferred from bed to wheel chair (WC) with the lift, the cloth on the WC seat back pulls R10's shirt up as he is lowered into WC. R10 indicated that if his urostomy is tucked into his pants, the bag may rupture or the ostomy wafer will peel off.

During an interview on 10/4/17, at 12:36 p.m. nursing assistant (NA)-E stated she had assisted R10 this morning and added, "Yes, his belly sticks out. We try to pull shirt down, but it does not always cover his belly."

A review of the Group 3 nursing assistant care sheet (undated), and R10's care plan (last signed 9/11/17), lacked documentation of instructions to staff to assure R10's clothes covered his stomach and ostomy bag.

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In an interview on 10/4/17, 12:53 p.m. social worker (SS)-A stated that the purchase of new clothing was discussed with family/guardians during R10's quarterly care conference in September. SS-A stated that the facility offered clothes from donations to the facility, however, neither the family/guardians nor R10 wanted R10 to wear "other peoples" clothes. SS-A stated he was informed the family/guardians would be buying new clothes but was unaware if this had ever occurred. SS-A stated that he would check with laundry services. SS-A stated that floor staff have been educated to adjust R10's clothing when his stomach and ostomy are exposed.

During an interview on 10/4/17, at 12:58 p.m. R10 verified that he was offered donated clothes, but refused. R10 stated his family/guardians were going to be buying him new clothing items.

On the same day, at 1:15 p.m. SS-A stated after checking with laundry, family/guardians had purchased only 2-3 pairs of pants.

In review of a facility policy, entitled: Clothing (effective July 2015), indicated: "1. Coordinate efforts between the resident and / or responsible party to ensure clothing needs are met" AND 2. Assist the resident in the procurement of needed items if requested by the resident."

R55's quarterly MDS dated 9/1/17, indicated R55 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R55 was frequently (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) incontinent of urine. Diagnoses included

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dementia and depression.

On 10/1/17, at 9:50 a.m. R55 was seated in her wheelchair in the doorway to her room. A dark brown substance was noted to be under her long fingernails on her right hand.

During observation on 10/1/17, at 11:10 a.m. R55 was seated in her wheelchair by the elevators and nursing desk. R55 smelled strongly of urine and was noted to be saturated in the area of her lap.

On 10/4/17, at 6:49 a.m. R55 was seated in her wheelchair near the elevator and nursing desk. R55 stated she had a shower the night before. A dark brown substance remained under her fingernails on her right hand.

During interview on 10/4/17, at 8:20 a.m. R55 stated the staff didn't clean her nails and it bothered her and made her feel "dirty."

During interview on 10/4/17, at 8:37 a.m. assistant director of nursing (ADON)- A stated residents should not have dirty fingernails and should not be sitting in urine soiled clothing. Further, dirty fingernails and urine soiled clothing which smelled of urine was undignified.

R2's significant change MDS dated 8/18/17, indicated R2 had moderate cognitive impairment and needed extensive assistance with dressing and personal hygiene. The MDS identified R2 was frequently incontinent of urine, with moisture associated skin damage. Diagnosis included was schizophrenia.

R2's ADL/Mobility care plan, last reviewed on 8/5/17, indicated R2 would be neat, clean and

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well groomed daily. The care plan directed staff to assist with personal hygiene, grooming, dressing and undressing with physical assistance. The care plan indicated R2 was resistant to therapy and ADLs and at times refused shaving. The care plan lacked approaches to refusal of cares. R2's Urinary Continence care plan, last reviewed 8/4/17, indicated R2 was incontinent and resident refuses to wear incontinent products and occasionally soils self. A behavior indicated R2 would lie in bed and urinate soiling himself and the bed and refused to be changed was noted, however, the care plan did not address how the staff should handle the behavior, other than to encourage him to change his clothing.

During observation on 10/2/17, at 2:10 p.m. R2 was standing at the nursing desk and had a strong urine smell. His sweatpants were saturated with urine in the front and back, as well as the right lower side of his shirt. R2 hair was uncombed and sticking up in multiple places. Multiple staff were located around the nursing desk and staff did not offer to take R2 back to his room and assist with changing his clothing or comb his hair. At 3:00 p.m. R2 was observed lying on his right side in bed, the back of his pants were saturated with urine. R2's room had a strong odor of urine present that could be smelled in the hallway.

On 10/3/17, at 10:12 a.m. R2 was walking in the hallway in front of the nursing desk, his shoes were untied, his hair was uncombed and sticking up in multiple places, his gray t-shirt had a tear in the back of the collar from one side of the neck to the other. ADON-A approached R2 and offered to tie his shoes. R2 allowed ADON-A to tie his

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shoes, however ADON-A did not offer to take him back to his room and help him change his shirt or comb his hair.

On 10/4/17, at 6:51 a.m. R2 was sitting in the dining room watching television. His hair was uncombed and was sticking up in multiple places. His gray t-shirt had a quarter sized hole in the front. R2 was in the dining room until 9:06 a.m. when he walked down the hall towards his room and laid in bed. Staff did not approach R2 and offer to change his shirt or comb his hair, during this time.

During interview on 10/4/17, at 8:47 a.m. social services assistant (SS)-A stated R2 had a brother that he had contacted in the past about getting new shoes and the brother bought him a new pair. SS-A stated he had not noticed the holes in R2's clothing and had not notified R2's brother, for help in obtaining new clothing. SS-A stated it was a resident's right to wear what they wanted, however, R2 would never complain about having holes in his clothing unless they were really large.

During interview on 10/4/17, at 9:12 a.m. NA-G stated R2 frequently removed his incontinent pad and would soil his clothing with urine. NA-G stated R2 needed to be checked every two hours and assisted with toileting needs, and any refusals were to be charted. Further, staff are aware when R2 was soiled, and needed assistance with cares but were unable to assist R2 due to the lack of staffing. NA-G stated although R2 was on her group this morning she did not assist him with cares, and wasn't sure who did. NA-G stated he was fairly independent but needed hands on assistance frequently and did allow staff to comb his hair and assist with changing his clothes, it just depended on how

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| 21805 | Continued From page 197<br>staff approached him.<br><br>During interview on 10/5/17, at 9:39 a.m. ADON-A stated it was unacceptable for a person to walk around in urine soiled clothing. ADON-A added urine odor, soiled clothing , clothes with holes and messy hair were undignified.<br><br>The facility policy Resident Rights dated 7/15, indicated: "The center promotes the resident right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the center. The center must protect and promote the rights of each resident...Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances dignity and respect in full recognition of your individuality."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with exposed body parts, are offered and assisted to appropriately cover their exposed skin and to ensure personal hygeine is maintained.<br><br>TIME PERIOD FOR CORRECTION: one (1) day. | 21805 | | |
| 21830 | MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 10. Participation in planning treatment; notification of family members. | 21830 | | 11/13/17 |

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(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or

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| 21830 | Continued From page 199<br>family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and<br>(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br>(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of | 21830 | | |

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| 21830 | Continued From page 200<br>the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to honor medication time choices for 1 or 4 residents (R48). In addition, the facility failed to honor food choices for 1 of 4 residents (R162) reviewed for choices.<br><br>Findings include:<br><br>R48's quarterly Minimum Data Set (MDS) dated 6/17/17, indicated R48 was cognitively intact and included diagnoses of anxiety and depression.<br><br>During interview on 10/1/17, at 3:45 p.m. R48 stated she wanted her evening medications given at 7:00 p.m. but they were scheduled for 8:00 p.m. and sometimes it took a really long time to receive her medications. R48 stated the nurses were aware and was told she had to come ask for them earlier.<br><br>During observation on 10/2/17, at 7:52 p.m. R48 was seated in her wheelchair next to the medication cart waiting for her evening medications.<br><br>R48's Medication Adminsitration Records (MAR) indicated the following:<br><br>October 2017-<br>- gabapentin 400 milligram (mg) 2 capsules by mouth (po) twice daily, scheduled for 8:00 a.m. and 8:00 p.m. | 21830 | Corrected | |

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- melatonin 3 mg 1 tab po at bedtime, scheduled for 8:00 p.m.
-ativan 0.5 mg 2 tabs po at 8:00 pm.
- morphine soluble tab 5 mg 2 tabs po at bedtime, scheduled for 9:00 p.m.
- morphine sulfate ER 15 mg 2 tabs po every evening, scheduled for 8:00 p.m.
- MAPAP rapid release gelcap 500 mg 2 tabs po three times daily, scheduled for 8:00 a.m., 12:00 p.m. and 8:00 p.m.

September 2017-
- gabapentin 400 milligram (mg) 2 capsules by mouth (po) twice daily, scheduled for 8:00 a.m. and 8:00 p.m.
- melatonin 3 mg 1 tab po at bedtime, scheduled for 8:00 p.m.
-ativan 0.5 mg 2 tabs po at 8:00 pm.
- morphine soluble tab 5 mg 2 tabs po at bedtime, scheduled for 9:00 p.m.
- morphine sulfate ER 15 mg 2 tabs po every evening, scheduled for 8:00 p.m.
- MAPAP (acetaminophen) rapid release gelcap 500 mg 2 tabs po three times daily, scheduled for 8:00 a.m., 12:00 p.m. and 8:00 p.m.

During interview on 10/3/17, at 2:53 p.m. registered nurse (RN)-G stated R48's evening medications were scheduled for 8:00 p.m. and was aware R48 wanted them scheduled for 7:00 p.m.. RN-G stated R48 had been requesting the medication time change for the last one to two months. RN-G stated she was a hospice patient and could not just change the medication times and was not aware if medication time preferences had been communicated to hospice.

During interview on 10/5/17, at 10:14 a.m. assistant director of nursing (ADON)-A stated she

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| 21830 | Continued From page 202<br>was not aware R48 wanted her evening medications scheduled for 7:00 p.m. rather than 8:00 or 9:00 p.m. ADON-A stated medications scheduled for twice daily or at bedtime could be changed by the nursing staff. The medications that are scheduled for a certain time would need to be communicated to hospice for changes.<br><br>The facility policy Resident Rights dated 7/15, indicated: "The center recognizes the resident's right to a quality of life that supports privacy, confidentiality, independent expression, choice, and decision making, consistent with State law and Federal regulation...You have the right to be fully informed in advance about care, treatment, and of any changes in the care or treatment that may affect your well-being and to participate in planning care and treatment or changes in care and treatment, unless you have been adjudged incompetent or found to be incapacitated under state law."<br><br>R162's quarterly MDS dated 08/17/17, indicated he was cognitively intact and did not have a poor appetite or over eating. R162's Nutrition Risk Care Plan dated 05/17, indicated he received a regular diet with large portions.<br><br>R162's Nutrition Risk Data Collection And Assessment dated 08/16/17, indicated he received regular diet with large portions.<br><br>During observation and interview on 10/02/17, at 12:20 p.m. nursing assistant (NA)-V was observed to bring R162 his room tray which had one brat, 1/2 corn on cob, a cup of baked beans and one ice cream cup. R162 stated that he had ordered two brats and two ice cream cups and that was it since he is on a high protein large portion diet. NA-V stated that he did not take his | 21830 | | |

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| 21830 | Continued From page 203 | 21830 | | |

order and that was not on his diet and that is what he was supposed to have. R162 stated, "I know what I had on my meal ticket and that is not what I wanted." R162 then stated, "This is not what I had on my F----ing ticket and I never should have came here [the facility]."

In follow up interview on 10/03/17, at 8:00 a.m. R162 stated he never was offered the second brat or ice cream as he requested during lunch on 10/02/17.

During phone interview on 10/03/17, at 12:17 p.m. the facility's registered dietician (RD)-A stated she did not have R162's chart in front of her but thought R162 should receive a double meat diet so he should had received a two meat portion at lunch on 10/02/17, and recommended to talk to the facility's dietary manager.

During interview on 10/03/17, at 1:40 p.m. dietary manager (DM)-A stated R162 was on a regular large portion diet and stated the nursing assistant should have checked on his diet after he became upset and that he should had been able to have the two brats and double ice cream as he requested.

SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident closes and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choses are being honored related medication administration times and foold choices.

TIME PERIOD FOR CORRECTION: Fourteen

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| 21830 | Continued From page 204 (14) days. | 21830 | | |
| 21855 | MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide personal privacy for 1 of 6 residents (R121) during observations of personal cares.<br><br>Finding include:<br><br>R121's diagnoses, as identified on physician's orders dated 9/28/17, included early onset Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 8/18/17, indicated R121 was totally dependent upon and required the physical assistance of two staff for bed mobility, eating, dressing, toileting and personal hygiene. The MDS also indicated R121 had a stage 4 pressure ulcer (open wound, with depth involving bone, muscle and supporting tissue).<br><br>During observation on 10/3/17, at 11:06 a.m. | 21855 | Corrected | 11/13/17 |

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| 21855 | Continued From page 205<br><br>nursing assistant (NA)-B was in R121's room, and pulled the window drapes shut to begin cares when registered nurse (RN)-B entered the room. RN-B began to gather supplies for a dressing change to R121's wound as NA-D also entered the room, and closed the door behind her. At 11:12 a.m., working on the exit side the bed, NA-D moved R121's gown, pulled down the bed sheet, and untied R121's incontinent brief, rolling the front onto itself, and tucked it between R121's legs. NA-B stood on the opposite side of the bed, while NA-D rolled R121 first toward the exit side of bed to remove the soiled brief, than back to the window side. NA-B held R121 as he faced the wall, while NA-D gathered R121's gown on his stomach, then pulled down the bed sheet, and cleansed R121's bottom with a cloth. Next, NA-D rolled R121 on his back, then cleaned R121's genital area. NA-D left R121's bedside to dispose of the wash cloths and get additional bedding and clothing, while NA-B stood next to R121 in bed, his genitals now fully exposed. At 11:15 a.m., while RN-B finished gathering and setting up supplies for the dressing change, R121 was on his back, his mid body, including genitals, were uncovered and fully exposed; a full minute passed. NA-B remained standing next to R121, and made no attempt to cover R121 while she waited for RN-B. At 11:16 a.m., RN-B started the dressing change, and NA-B rolled and held R121 on his left side, facing the wall as RN-B tended to R121's wound. During the entire treatment, R121's genitals remained exposed, and NA-B made no attempt to provide cover for R121's exposed body areas. At 11:22 a.m., following application of a top dressing, RN-B stepped away from the bed and R121 was rolled on his back, genitals still fully exposed. NA-D and NA-B resumed cares and placed a new brief on R121 at 11:24 a.m., nine minutes after the dressing | 21855 | | |

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change began.

For a full minute before, then during, and following R121's dressing change, staff allowed R121's private body area to be exposed, even though a bed sheet, gown, and other towels were accessible to use as a cover.

When interviewed on 10/3/17, at 11:57 a.m. NA-B stated to help guard a resident's privacy staff have to shut the door, pull the curtain, and use a sheet to cover [R121]. NA-B acknowledged that during cares and dressing change, R121 was left uncovered for a long time, was exposed, and stated, "I think I should have covered him up better."

During an interview on 10/4/17, at 9:23 a.m. the assistant director of nursing (ADON) stated residents should be covered to the extent possible during the provision of cares. The ADON stated she considered this "a matter of dignity and privacy" for R121, and for all residents.

A facility policy, Confidentiality and Privacy, dated July 2015, directed: "Provide resident privacy when receiving treatment and care for personal needs."

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or designee could review/revise policies and re-educate all staff on the appropriate provision of privacy during personal care. The DON and/or designee could conduct audits of resident cares to ensure resident privacy is maintained and needs are met.

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| 21855 | Continued From page 207<br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21855 | | |
| 21870 | MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure they had followed up on concerns presented at resident council meetings to the residents. This affected 24 residents (R6, R10, R11, R12, R13, R14, R21, R31, R34, R39, R43, R44, R50, R58, R65, R66, R73, R79, R96, R106, R116, R127, R135, R179) who have participated in the resident council meetings.<br><br>Findings include:<br><br>During interview on 10/1/17, at 10:14 a.m. the resident council representative, R31 stated, "We are not getting anywhere with anything." R31 stated there have been concerns regarding closure of the resident store, understaffing at the facility, slow response to call lights, variance of time of medication administration in the morning from 7:30 a.m. and 11:30 a.m., and there was an extended period of time before residents who were incontinent received care by the facility staff.<br><br>R31 also stated personal grievances had been filed on 4/7/17, 4/14/17 and 9/11/7, related to staffing and provision of cares. He stated he had | 21870 | Corrected | 11/13/17 |

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not yet received responses in follow up to the grievances filed, either in writing or by any staff. R31 stated he has kept the documents to demonstrate the concerns that had been submitted.

A review of the resident council meeting minutes from 3/2/17 to 9/7/17 identified the following:

-3/2/17, resident concerns regarding the length of time it took to have call lights answered, and failure to provide care when lights were answered. The minutes also identified an update from the Ombudsman of the resident right to have the facilty follow up with residents if a complaint is filed and an investigation was completed. The meeting was noted to have been attended by the following resdient's: R6, R21, R50, R58, R65, R73, R12.

-4/6/17, information was provided to residents regarding the plans for the new smoking patio that will be built outside of the 1st floor double doors. The meeting minutes did not reflect concerns identified from the meeting of 3/2/17. The meeting was noted to be attended by the following residents:R10, R13, R21, R34, R58, R66, R79, R106.

-5/4/17, concerns regarding not enough staff and not receiving medications or cares on time. Previous concerns addressed or resolutions identified were not addressed in the meeting minutes. The meeting was attending by the following residents: R10, R11, R12, R13, R14, R21, R31, R34, R39, R43, R44, R50, R58, R65, R66.

- 6/1/17, concerns and requests were made related to the process for the resumption of the

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resident store and refreshment desired for the council meetings. The minutes did not address previous concerns or resolution to concerns identified. The meeting was attended by the following residents: R10, R11, R12, R21, R31, R44, R65, R66, R73, R106, R135.

-7/6/17, concerns were identified related to resumption of the resident store. The meeting minutes not address previous concerns or resolution to concerns identified. The meeting was attended R10, R11, R12, R21, R31, R43, R58, R106, R116, R179.

-8/3/17, The Resident Council president requested all nursing related complaints be routed to the director of nursing for follow through. The minutes also reflected the residents inquired whether legal services were available to sue the facility to implement nurses/aides being available. The minutes identified concerns management staff should be cut instead of front line staff (nurses, aides).
Resident attendance was not outlined in the meeting minutes to reflect members present.

-9/7/17, minutes did not address any responses to the concerns previously identified. There was a "new business" heading included potentially speaking with state legislators to change laws for aide care/staff aide to resident ratio. Resident attendance was not outlined in the meeting minutes to reflect which members were present.

During interview on 10/5/17, at 10:48 a.m. the director of social services (DSS) stated he had been acting as the liaison of the resident council since July of 2017. In this role, the DSS stated there continued to be discussion regarding the desire to resume the resident store, however, at

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this time there are no plans in place. The DSS stated there were multiple concerns identified regarding grievances related to nursing and staffing concerns. These concerns were routed to the executive director (ED) to review and follow through. The DSS stated staffing was frequently addressed but there has been no resolution of staffing concerns, and these residents were also able to file written grievances and noted R31 had expressed lack of follow through regarding written concerns.

During interview on 10/5/17, at 2:35 p.m. the ED stated the facility had identified the need for follow through on resident council concerns, however, stated there was not a plan formalized as to how this would be done. The ED stated grievances which had been filed were followed up on, however, stated prior to her appointment as ED approximately one month ago, there had not been a formalized process for follow up. The ED stated she was aware of residents concerns regarding staffing and provision of cares and they were still working on these concerns.

A policy, effective July 2015, titled, Resident Council identified under Procedure: bullet number four the council will report concerns/grievances to the ED and/or responsible party who will subsequently prepare a response to any concerns/grievances from the council. This response is to be provided in writing by the facility by completing the Resident Concern Report.

Although multiple resident council minutes identified resident concerns, there was no indication the facilty had completed follow up of these concerns, and promptly responded to the resident council members.

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| **GOLDEN VALLEY REHABILITATION AND CARE** | **7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21870 | Continued From page 211<br><br>SUGGESTED METHOD OF CORRECTION: The admininstrator and/or designee could educate facility staff involved with resident council, to assure concerns are not only heard but are responded to in an apporpriate time frame and manner.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21870 | | |