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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1N2E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00324

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245542**

2.STATE VENDOR OR MEDICAID NO.
(L2) **477605100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLEFORK MEDICAL CENTER**
(L4) **912 MAIN STREET**
(L5) **LITTLEFORK, MN** (L6) **56653**

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) **04/01/2016**

6. DATE OF SURVEY **09/15/2016** (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 **45** (L18)

13.Total Certified Beds **45** (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
	45			
(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):

17. SURVEYOR SIGNATURE — Date :
Rebecca Haberle, HFE NEII — 10/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 10/25/2016 (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
04/24/1991
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 29, 2016

Ms. Carrie Claybundy, Administrator
Littlefork Medical Center
912 Main Street
Littlefork, Minnesota 56653

RE: Project Number S5542025

Dear Ms. Claybundy:

On September 15, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 25, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 25, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) 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 remedies will not be imposed. 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by December 15, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 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 electronic 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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(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
F 000	INITIAL COMMENTS 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		10/21/16

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

Electronically Signed | 10/09/2016

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 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency and administrator 1 of 1 resident (R13) allegation of mistreatment and failed to immediately report and conduct a thorough investigation of resident to resident altercations for potential abuse and neglect. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/2/16, indicated R13 had diagnoses of dementia and anemia. The MDS indicated R13 was alert and orientated, displayed mood indicators such as having difficulty concentrating on topics, and displayed verbal and physically aggressive behaviors towards others. The MDS indicated R13 required extensive assistance of two staff for activities of daily living.	F 225	KHS aspires to report and investigate all allegations of maltreatment. R13 and all residents of KHS have been interviewed regarding their feelings of safety and security in their interactions with other residents and with staff. This interview process was completed as of 9/29/16. Any resident concerns were immediately reported to the OHFC VA reporting website and further investigated for follow up and interventions. R13 care plan has been reviewed and changes made to the resident care plan as appropriate. R13 has been seen by her Mental Health Provider on 9/23/16, medications adjusted accordingly. Nursing is to monitor behaviors every shift and report findings to Mental Health Provider on or before her next visit if needed. Facility entered into a contract	

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F 225	Continued From page 2 R13's care plan dated 6/9/15, indicated R13 displayed cognitive loss/dementia due to confusion and forgetfulness at time. The plan also identified R13 as a vulnerable adult and had a history of being very rude, demeaning and inappropriate towards staff and other residents. R13 had a history of delusional thoughts and false accusations against others and had been verbally and physically aggressive towards others. An Incident Report - Investigative Report Submission form dated 8/8/16, indicated on 8/7/16, R13 had reported to the staff that an unidentified licensed practical nurse (LPN) had pushed her down to her room and hit her foot against the bed frame causing injury to her foot. The report indicated R13 had reported the concern to the staff on 8/7/16, however, the report had not been reported to the administrator or the State agency until 8/8/16. A Progress Note dated 8/8/16, at 12:51 p.m. indicated R13 had expressed concerns related to the identified LPN and R13 was noted to have "slight bruising on the right foot." On 9/12/16, at 4:40 p.m. R14, an alert and oriented resident, stated R13 was verbally aggressive towards other residents. She stated R13 had yelled and hit her during activities. R14 stated she tried to make sure she was not near R13. On 9/13/16, at 6:10 a.m. R34, an alert and oriented resident, stated R13 would become verbally abusive towards the other residents and staff. R34 stated he had witnessed the incidents of verbal aggression towards other residents in the dining room, but had not reported them as the	F 225	with the resident regarding any verbal and physical aggression toward others. If the resident continues to exhibit these behaviors, the plan will be to separate her from other residents during these activities. If the behavior proceeds after this intervention, will assess for Behavioral treatment and or alternate placement. To address how the facility will act to protect residents in similar situations, all residents or their representative will be asked specifically during their quarterly assessment and care conference process if they feel safe in our facility, if staff treat them well and if they are bothered by other residents in any way. To address the lack of investigation, both R14 and R34 were individually encouraged on 9/16/16 to report their concerns to any staff member. Concerns brought forth at that time were investigated and reported to OHFC VA website as stated above. Staff will be re-educated on the reporting policy as mentioned below to ensure timely and accurate reporting, so that further follow up can be pursued. Further, a special RN meeting will be held on 10/20/16 to provide specific education to RN's who oversee the staff and resident interactions on a daily basis. Will review case studies and examples of reportable incidents as well as the facility policy to ensure investigations are initiated immediately and reported timely. Resident council will also be addressed on 10/20/16 to offer education on reporting concerns, who they should be reported to, and what the different options	

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F 225	Continued From page 3 staff were present in the dining room at the time of the incidents. R34 was not able to recall the specific date or time of the incident. R13's Resident Progress Notes dated 8/15/16, indicated R13 had been very rude to other residents. R13 wished to go into a community restroom, but another (unidentified) resident was in the restroom. R13 became verbally abusive toward the staff and told the staff she was going to slap them in the face. The documentation indicated R13 "has been very offensive to other residents today." Two male residents stated that they don't even like to be in the same area as her. On 9/14/16, at 2:00 p.m. the licensed social worker, (LSW) stated R13's physical behaviors, verbal altercations and false accusations were directed at the staff members and not other residents. The LSW stated she was unaware of other residents concerns and allegations related to R13's behaviors and that other residents did not want to be in the same areas as R13. On 9/14/16, at 2:05 p.m. the director of nurses (DON) stated R13's behaviors were directed at the staff and not at other residents. On 9/14/16, at 2:15 p.m. the assistant administrator stated the facility was aware of and had looked into concerns related to R13's behaviors towards the staff members, however, was not aware of concerns related to R13's behaviors towards other residents. The assistant administrator confirmed R13's behaviors towards others increased her risk of abuse from others. On 9/15/16, at 8:53 a.m. R14 stated R13 had hit her in early August 2016. She stated the incident	F 225	of reporting are (in person, on paper). The resident council will have resident concern forms available for use at that time. Because some concerns were unknown, some were reported, and some were not, All staff will be re-educated on the definitions of and reporting all allegations of mistreatment as per facility policy by 10/21/16. Progress notes will be audited on a daily basis to determine any documentation that would possibly sound like a VA issue. Progress note audit results and report on VA issues will be brought to the QAPI Committee for review and further recommendations.	

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F 225	Continued From page 4	F 225		

occurred during an activity. She had reported the concern to the activity staff and stated she was not afraid of R13 but always made sure that she was not seated near R13 during activities.

On 9/15/16, at 8:14 a.m. activity aide (AA)-A stated she was aware R14 had reported to her that R13 had hit her during activities. She stated R13 would become verbally abusive towards others especially when it was time to choose Bingo prizes. AA-A stated she reported R14's concern of being hit by R13 to the charge nurse, but could not recall which nurse she had spoken to regarding the concern.

R13's Progress Notes from 7/1/16, - 9/15/16, did not include documentation related to R13 striking R14.

On 9/15/16, at 9:10 a.m. the assistant administrator verified the incident report dated 8/7/16, had not been reported immediately as directed by the policy. Upon review of the progress note dated 8/15/16, the assistant administrator verified the identified concern of two male residents not wishing to be near R13 should have been reported and investigated to determine if potential abuse had occurred or if further interventions were needed. She stated she had not been made aware of R13 hitting R14 which should have been reported immediately and investigated per facility policy.

The Maltreatment Prohibition Policy dated 8/2009, and amended on 8/10/16, defined abuse as physical, sexual, verbal, psychological, or resident to resident abuse. The policy directed the staff to report any allegations of potential

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F 225	Continued From page 5 abuse and neglect to the administrator and the State agency immediately. The Prohibiting Mental Abuse and Protecting Resident Privacy update on 8/10/16, directed staff to report all allegations of abuse, provide protections for any resident involved in the allegations, conduct a thorough investigation, implement corrective actions to prohibit further abuse and to report the findings as required.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their policy and procedures related to the immediate reporting to the adminstrator and State agency for 1 of 1 resident (R13) in the sample who had reported an allegation of staff mistreatment. In addition, failed to conduct a thorough investigation and immediately report resident to resident altercations for possible abuse and neglect. Findings include: The Maltreatment Prohibition Policy dated 8/2009, and amended on 8/10/16, defined abuse as physical, sexual, verbal, psychological, or resident to resident abuse. The policy directed	F 226	KHS aspires to report and investigate all allegations of maltreatment. R13 and all residents of KHS have been interviewed regarding their feelings of safety and security in their interactions with other residents and with staff. This interview process was completed as of 9/29/16. Any resident concerns were immediately reported to the OHFC VA reporting website and further investigated for follow up and interventions. R13 care plan has been reviewed and changes made to the resident care plan as appropriate. R13 has been seen by her Mental Health Provider on 9/23/16, medications adjusted accordingly.	10/21/16

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F 226	Continued From page 6 the staff to report any allegations of potential abuse and neglect to the administrator and the State agency immediately. The Prohibiting Mental Abuse and Protecting Resident Privacy update on 8/10/16, directed staff to report all allegations of abuse, provide protections for any resident involved in the allegations, conduct a thorough investigation, implement corrective actions to prohibit further abuse and to report the findings as required. R13's quarterly Minimum Data Set (MDS) dated 6/2/16, indicated R13 had diagnoses of dementia and anemia. The MDS indicated R13 was alert and orientated, displayed mood indicators such as having difficulty concentrating on topics, and displayed verbal and physically aggressive behaviors towards others. The MDS indicated R13 required extensive assistance of two staff for activities of daily living. R13's care plan dated 6/9/15, indicated R13 displayed cognitive loss/dementia due to confusion and forgetfulness at time. The plan also identified R13 as a vulnerable adult and had a history of being very rude, demeaning and inappropriate towards staff and other residents. R13 had a history of delusional thoughts and false accusations against others and had been verbally and physically aggressive towards others. An Incident Report - Investigative Report Submission form dated 8/8/16, indicated on 8/7/16, R13 had reported to the staff that an unidentified licensed practical nurse (LPN) had pushed her down to her room and hit her foot against the bed frame causing injury to her foot.	F 226	Nursing is to monitor behaviors every shift and report findings to Mental Health Provider on or before her next visit if needed. Facility entered into a contract with the resident regarding any verbal and physical aggression toward others. If the resident continues to exhibit these behaviors, the plan will be to separate her from other residents during these activities. If the behavior proceeds after this intervention, will assess for Behavioral treatment and or alternate placement. To address how the facility will act to protect residents in similar situations, all residents or their representative will be asked specifically during their quarterly assessment and care conference process if they feel safe in our facility, if staff treat them well and if they are bothered by other residents in any way. To address the lack of investigation, both R14 and R34 were individually encouraged on 9/16/16 to report their concerns to any staff member. Concerns brought forth at that time were investigated and reported to OHFC VA website as stated above. Staff will be re-educated on the reporting policy as mentioned below to ensure timely and accurate reporting, so that further follow up can be pursued. Further, a special RN meeting will be held on 10/20/16 to provide specific education to RN's who oversee the staff and resident interactions on a daily basis. Will review case studies and examples of reportable incidents as well as the facility policy to ensure investigations are initiated immediately and reported timely.	

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F 226	Continued From page 7 The report indicated R13 had reported the concern to the staff on 8/7/16, however, the report had not been reported to the administrator or the State agency until 8/8/16. A Progress Note dated 8/8/16, at 12:51 p.m. indicated R13 had expressed concerns related to the identified LPN and R13 was noted to have "slight bruising on the right foot." On 9/12/16, at 4:40 p.m. R14, an alert and oriented resident, stated R13 was verbally aggressive towards other residents. She stated R13 had yelled and hit her during activities. R14 stated she tried to make sure she was not near R13. On 9/13/16, at 6:10 a.m. R34, an alert and oriented resident, stated R13 would become verbally abusive towards the other residents and staff. R34 stated he had witnessed the incidents of verbal aggression towards other residents in the dining room, but had not reported them as the staff were present in the dining room at the time of the incidents. R34 was not able to recall the specific date or time of the incident. R13's Resident Progress Notes dated 8/15/16, indicated R13 had been very rude to other residents. R13 wished to go into a community restroom, but another (unidentified) resident was in the restroom. R13 became verbally abusive toward the staff and told the staff she was going to slap them in the face. The documentation indicated R13 "has been very offensive to other residents today." Two male residents stated that they don't even like to be in the same area as her." On 9/14/16, at 2:00 p.m. the licensed social	F 226	Resident council will also be addressed on 10/20/16 to offer education on reporting concerns, who they should be reported to, and what the different options of reporting are (in person, on paper). The resident council will have resident concern forms available for use at that time. Because some concerns were unknown, some were reported, and some were not, All staff will be re-educated on the definitions of and reporting all allegations of mistreatment as per facility policy by 10/21/16. Progress notes will be audited on a daily basis to determine any documentation that would possibly sound like a VA issue. Progress note audit results and report on VA issues will be brought to the QAPI Committee for review and further recommendations.	

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worker, (LSW) stated R13's physical behaviors, verbal altercations and false accusations were directed at the staff members and not other residents. The LSW stated she was unaware of other residents concerns and allegations related to R13's behaviors and that other residents did not want to be in the same areas as R13.

On 9/14/16, at 2:05 p.m. the director of nurses (DON) stated R13's behaviors were directed at the staff and not at other residents.

On 9/14/16, at 2:15 p.m. the assistant administrator stated the facility was aware of and had looked into concerns related to R13's behaviors towards the staff members, however, was not aware of concerns related to R13's behaviors towards other residents. The assistant administrator confirmed R13's behaviors towards others increased her risk of abuse from others.

On 9/15/16, at 8:53 a.m. R14 stated R13 had hit her in early August 2016. She stated the incident occurred during an activity. She had reported the concern to the activity staff and stated she was not afraid of R13 but always made sure that she was not seated near R13 during activities.

On 9/15/16, at 8:14 a.m. activity aide (AA)-A stated she was aware R14 had reported to her that R13 had hit her during activities. She stated R13 would become verbally abusive towards others especially when it was time to choose Bingo prizes. AA-A stated she reported R14's concern of being hit by R13 to the charge nurse, but could not recall which nurse she had spoken to regarding the concern.

R13's Progress Notes from 7/1/16, - 9/15/16, did

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F 226	Continued From page 9 not include documentation related to R13 striking R14. On 9/15/16, at 9:10 a.m. the assistant administrator verified the incident report dated 8/7/16, had not been reported immediately as directed by the policy. Upon review of the progress note dated 8/15/16, the assistant administrator verified the identified concern of two male residents not wishing to be near R13 should have been reported and investigated to determine if potential abuse had occurred or if further interventions were needed. She stated she had not been made aware of R13 hitting R14 which should have been reported immediately and investigated per facility policy.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		10/21/16

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F 280	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include repositioning directives and range of motion services for 2 of 5 residents (R21, R8) who were dependent upon staff for repositioning and range of motion. Findings include: R21's care plan was not revised to include the timing of repositioning needs or range of motion needs. R21's care plan edited on 6/2/16, indicated R21 required assistance with turning and repositioning, however, the plan did not direct the staff as to how often she was to receive assistance. In addition, the plan did not include a range of motion plan. R21's physical therapy Progress Note dated 12/4/15, indicated R21 utilized a three pound weight for upper extremity active range of motion and lower extremity strengthening. On 9/13/16, from 12:30 to 3:22 p.m. R21 was continuously observed to sit in her wheelchair without repositioning assistance. R21 was observed during this time to use her arms and legs to propel her wheelchair throughout the facility.	F 280	KHS reviews and revises the resident's care plan after each assessment and or changes in condition. R8 care plan was reviewed and revised to include repositioning directives and range of motion services (ROM), and the NAR care sheet updated accordingly. R21 care plan was reviewed and revised to include repositioning directives and range of motion services, NAR care sheet updated accordingly. All other residents at risk for skin breakdown (moderate to high risk on their Braden) have the potential to be affected and their care plans will be reviewed/revised as needed to ensure there is direction for repositioning according to their skin assessment. All other residents with ROM services ordered will have their care plan reviewed/revised as needed to ensure appropriate direction for ROM services. NAR care sheets will be updated with the appropriate repositioning Restorative plan for each resident. Further, a special RN meeting will be held on 10/20/16 to provide specific education to RN's who complete care planning for ROM, toileting and repositioning. RN staff to also address individualized care planning each individual resident as it may not fit the standard. Will cover the assessment process required to complete individualized care planning also.	

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F 280	Continued From page 11 -At 3:22 p.m. nursing assistant (NA)-I assisted R21 from the dining room to the resident restroom by the nurses station. -At 3:27 p.m. R21 was observed to stand with physical assistance of NA-I by pulling herself up with the grab bars in the restroom. R21's skin was observed to be intact. A pressure redistribution cushion was on her wheelchair. On 9/13/16, at 3:28 p.m. NA-I stated she had no way of knowing when the last time R21 had been assisted to the restroom/repositioned. She stated she had started her shift at 2:30 p.m. and the day shift had not reported when they had last assisted R21. On 9/13/16, at 3:30 p.m. NA-D stated she had assisted R21 to transfer/reposition at 11:30 a.m. a total of 4 hours earlier. On 9/14/16, from 6:59 a.m. to 10:15 R21 was continuously observed seated in her wheelchair. On 9/14/16, at 10:11 a.m. NA-C stated she had assisted R21 out of bed at 6:30 a.m. and had not assisted her with cares since that time. A total of 3 hours and 45 minutes. -At 10:15 a.m. NA-C wheeled R21 from the dining room to the restroom by the nurses station. R21 was observed to assist to transfer by utilizing the grab bars in the restroom. R21's buttocks was observed to be pink and intact. The pressure redistribution cushion remained on the wheelchair.	F 280	NAR staff will be re-educated on the resident's toileting, repositioning and ROM care plans. NAR staff will be asked to prepare shift to shift communication to pass along to the next shift for toileting times and ROM completion with LPN oversight. DON or designee will do random audits to ensure appropriate repositioning and Restorative ROM plans are care planned 2 x weekly for 4 weeks and then weekly for 4 weeks, and then monthly thereafter. Audit results will be brought to the QAPI Committee for further review and recommendations.	

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On 9/14/16, at 12:20 p.m. the director of nursing (DON) stated R21 was to receive assistance with reposition every two hours. She verified this was not addressed on the care plan and should have been.

On 9/15/16, at 9:45 a.m. PT-A stated when a resident was discontinued from therapy, a verbal functional maintenance program was established and direction would have been given to the nursing staff. She stated if upper extremity range of motion had been provided by therapy, then a range of motion program would have been included in the functional range of motion program for the nursing staff to continue. PT-A stated this plan should have been added to the care plan.

On 9/15/16, at 10:30 a.m. R21 was observed resting in bed. The DON directed R21 to lift her arms and touch her head. R21 was not observed to have a limitations in her upper extremities. The DON verified R21's care plan did not include directions for range of motion.

R8's care plan was not revised to include the timing of repositioning needs and range of motion needs.

A Progress Note dated 12/4/16, completed the physical therapist indicated R8 was participating a seated strengthening exercises including knee extensions, hip flexion, resisted knee flexion, ankle ROM and utilized a three pound weight for upper extremity strengthening

R8's care plan edited on 7/12/16, indicated R8

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was not at risk for skin breakdown but did have risk factors such as incontinence of urine and spending most of the day in a wheelchair. The plan did not indicate how often R8 was to receive assistance with repositioning. In addition, the plan did not direct the staff to provide range of motion services.

The Point of Care electronic record did not indicate R8 was receiving a range of motion program.

On 9/14/16, from 7:00 a.m. to 9:35 a.m. R8 was continuously observed seated in her wheelchair without repositioning assistance.
- At 7:51 a.m. NA-C wheeled R8 to the dining room table. R8 was able to feed herself the meal.
-At 9:35 a.m. NA-A wheeled R8 to the resident restroom by the nurses station. NA-A assisted R8 from the wheelchair to the toilet. R8's wheelchair was observed to be equipped with a pressure redistribution cushion. R8's skin was pink and intact. At no time during the observation was R8 observed to attempt to reposition herself.
-At 9:42 a.m. NA-A stated she did not know when the last time R8 had been assisted with repositioning.
-At 9:43 a.m. NA-G stated R8 was assisted up at 6:00 a.m. NA-G verified R8 had not been assisted with repositioning for 3 hours and 35 minutes.
- At 11:47 a.m. NA-A stated R8 did not receive range of motion services.

On 9/15/16, at 10:40 a.m. the DON stated R8 was not able to reposition herself and was to be assisted every 2 hours with repositioning, However, this had not been added to the care plan. She verified R8's range of motion program

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F 280	Continued From page 14 had not been added to the care plan. The Care Plan policy dated 9/1/15, directed the staff to assess the residents and develop care plan to provide care to the residents based on their individualized needs.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ambulation assistance was provided as directed by the care plan for 3 of 3 residents (R1, R8, R21) who required assistance with ambulation; Failed to provide repositioning assistance as directed by the care plan for 2 of 5 residents (R6, R22) who required staff assistance to reposition and failed to provide toileting/incontinence care assistance as directed by the care plan for 4 of 5 residents (R1, R8, R21, R22) who were incontinent of urine and required staff assistance to toilet. Lastly, the facility failed to provide grooming assistance related to the removal of facial hair as directed by the care plan for 2 of 2 residents (R21, R22) who required staff assistance with shaving needs. Findings include:	F 282	KHS goal is to provide services by qualified persons in accordance with the resident's plan of care. R1, R8 and R21 will be ambulated as directed by the care plan. R1, R8 and R21 ambulation needs were reassessed and staff caring for R1, R8 and R21 were re-educated on their plan of care. R6 and R22 will be repositioned as directed by their plan of care. R6 and R22 repositioning needs were reassessed and interventions were developed based on the results of the assessment. Staff caring for R6 and R22 were re-educated on their plans of care. R1, R8 and R21 will be offered toileting assistance as directed by their plan of care. R1, R2, R8 and R22 toileting needs were reassessed and interventions were developed based on the assessment.	10/21/16

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F 282	Continued From page 15 R1 did not receive toileting and ambulation assistance as directed by the care plan. R1's care plan dated 7/21/16, directed staff to assist R1 to the toilet every two hours and to ambulate to and from all meals with two staff assist. The plan also indicated R1 was to ambulate for 10 minutes twice a day for a minimum of 15 minutes total. On 9/13/16, a.m. was R1 was observed at meal time. From 8:00 a.m. to 9:30 a.m. R1 was not provided ambulation to and from the breakfast meal. On 9/14/16, at 6:50 a.m. R1 was observed in the dining room in her Rock and Go wheelchair watching TV. -At 8:15 a.m. NA-A and NA-B transferred R1 into a dining room chair at the dining table for breakfast. -At 8:52 a.m. following the completion of breakfast, NA-A and NA-B transferred R1 back into her wheelchair and proceeded to wheel R1 to activities. No ambulation was provided to and from the breakfast meal, as directed. R1 was not observed to receive assistance until 10:05 a.m. -At 10:05 a.m. NA-A wheeled R1 into the bathroom. NA-A and NA-B transferred R1 on to the toilet. R1 was incontinent of urine. (5:45 a.m.-10:05 a.m. 4 hours and 20 minutes). -At 10:10 a.m. NA-A wheeled R1 into the activity area. -At 11:55 a.m. R1 was wheeled out of activities by NA-A and wheeled into the dining room. -At 12:10 p.m. NA-A and NA-B transferred R1 from the wheelchair into a dining room chair. NA-A proceeded to feed R1 her lunch meal.	F 282	Staff caring for R1, R2, R8 and R22 were re-educated on their plans of care. R21 and R22 will be offered grooming assistance to remove facial hair as directed by their care plan. R21 and R22 were reassessed and interventions developed based on the results of the reassessment. Staff caring for R21 and R22 were re-educated on their plans of care. All residents have care plans that must be followed by staff caring for the residents. Care plans remain readily available for all staff providing direct care services to residents. NAR staff were re-educated on the availability of the plan of care. NAR staff will report off to the next shift as to the time the resident was last toileted or repositioned. DON or designee will conduct random observational audits to ensure plans of care related to restorative programs, repositioning, toileting, and grooming (shaving) are being followed. 2 x weekly for 4 weeks, then weekly for 4 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 282	Continued From page 16 -At 12:30 p.m. NA-A continued to feed R1. -At 12:55 p.m. R1 was assisted to the bathroom. R1's brief was noted to be wet with urine. (2 hours and 45 minutes without toileting/reposition assistance). On 9/14/16, at 10:15 a.m. NA-A confirmed R1 was not ambulated to and from meals on 9/14/16, and stated it "got very busy" at meal time therefore ambulation did not always get done. NA-A also confirmed R1 was to be toileted every 2 hours and was not. On 9/15/16, at 8:35 a.m. the director of nursing (DON) verified R1's care plan was correct and R1 should have been provided every two hours toileting and ambulation assistance, as directed. R6 was not provided every two hour repositioning assistance on 9/14/16, as directed by the care plan. R6's care plan dated 6/30/16, indicated R6 was to be repositioned by staff every two hours. On 9/14/16, from 6:50 a.m. until 10:00 a.m. R6 was continuously observed. -At 6:50 a.m. R6 was in the dining room, seated in the wheelchair. -At 7:45 a.m. the speech therapist (ST) wheeled R6 out of dining room and to the therapy room. -At 8:10 a.m. the ST wheeled R6 back into the dining room. -At 8:30 a.m. R6 was eating breakfast. -At 8:35 a.m. the assistant administrator wheeled R6 out of dining room to the nurse's desk. -At 8:45 a.m. R6 remained seated the wheelchair and attended activities for exercises.	F 282		

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F 282	Continued From page 17 -At 9:15 a.m. R6 wheeled self into his bathroom to shave. -At 9:45 a.m. licensed practical nurse (LPN) -A completed a dressing change to R6's foot wound. R6 remained seated in the wheelchair. -At 9:50 a.m. NA-A wheeled R6 into the large bathroom by the nurse's desk. NA-A and NA-C proceeded to assist R6 onto the toilet via a mechanical lift. The North #1 Toileting and Repositioning sheet, updated 9/2/16, indicated on 9/14/16, R6 was last repositioned at 6:30 a.m. On 9/14/16, at 10:15 a.m. NA-A stated by looking at the toileting and repositioning sheet that was located in the service room, confirmed R6 was last repositioned at 6:30 a.m. three hours and 20 minutes earlier. NA-A stated R6 was to be repositioned every two hours. On 9/15/16, at 8:10 a.m. the DON verified R6's care plan was correct and was not followed, as directed. R8 did not receive assistance with toileting as directed by the care plan. R8's care plan edited on 6/8/15, indicated R8 was occasionally incontinent of bladder and utilized incontinent products. The plan directed staff to assist R8 with toileting every two hours. On 9/14/16, from 7:00 a.m. to 9:30 a.m. R8 was continuously observed. -At 7:00 a.m. R8 was in the dining room seated in a wheelchair, asleep.	F 282		

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F 282	Continued From page 18 -At 7:51 a.m. NA-C wheeled R8 to the breakfast table. -At 8:06 a.m. R8 was served breakfast. R8 was observed to eat the meal independently. -At 9:20 a.m. R8 finished the meal and fell asleep at the dining room table. -At 9:35 a.m. NA-A wheeled R8 to the resident restroom by the nurses station and proceeded to assist R8 from the wheelchair to the toilet. R8 was observed to be incontinent of urine. NA-A assisted R8 to change her incontinent product. At 9:43 a.m. NA-G stated R8 was last provided cares at 6:00 a.m. NA-G verified R8 had not been assisted with toileting for 3 hours and 35 minutes. On 9/15/16, at 10:40 a.m. the DON stated R8 was dependent upon the staff for assistance with toileting. She verified R8 was to receive assistance every two hours as directed by the care plan. R21 did not receive timely assistance with incontinence cares and ambulation as directed by the care plan. R21's care plan edited on 6/2/16, indicated R21 was incontinent of bladder and directed the staff to toilet and assist with toileting every two hours. R21's care plan edited on 8/12/16, indicated R21 had sustained a decline in ambulation related to advanced dementia as evidenced by generalized weakness. The plan directed R21 to ambulate to meals twice a day with assistance of one or two	F 282		

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F 282	Continued From page 19	F 282		

staff as needed.

On 9/13/16, at 12:38 p.m. R21 was observed seated in a wheelchair in the dining room.
-At 1:15 p.m. NA-H wheeled R21 from the dining room to the lobby / TV room.
-At 2:00 p.m. R21 was wheeled from the lounge area to the activity room by activity aide (AA)-A.
-At 2:46 p.m. AA-A wheeled R21 back to the dining room.
-At 3:22 p.m. NA-I assisted R21 from the dining room to the resident restroom by the nurses station.
-At 3:27 p.m. R21 was observed to stand with physical assistance of NA-I. R21 was observed to be incontinent of urine.

On 9/13/16, at 3:28 p.m. NA-I stated she had no way of knowing when the last time R21 had been assisted to the restroom. She stated she had started her shift at 2:30 p.m. and the day shift had not reported when they had last assisted R21.

On 9/13/16, at 3:30 p.m. NA-D stated she had assisted R21 transfer to the restroom at 11:30 a.m. a total of 4 hours earlier.

On 9/14/16, from 6:59 a.m. to 10:15 a.m. R21 was continuously observed.
-At 6:59 a.m. R21 was seated in a wheelchair wheeling herself up and down the hallways with her feet.
-At 7:52 a.m. NA-C wheeled R21 to the dining room table.
-At 9:02 a.m. R21 finished her meal and began wheeling herself out of the dining room and down

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F 282	Continued From page 20 the north hallway. -At 10:03 a.m. R21 wheeled herself into the dining room for morning coffee. -At 10:11 a.m. NA-C stated she had assisted R21 out of bed at 6:30 a.m. and had not assisted her with cares since that time. A total of 3 hours and 45 minutes. R21 was not observed to receive assistance to ambulate before or after the meals on 9/13/16, at 1:14 p.m., on 9/14/16, at 7:00 a.m. or at 9:02 a.m. at 11:47 a.m. or at 1:05 p.m. On 9/14/16, at 12:20 p.m. the DON stated R21 was to receive assistance with toileting every two hours as directed by the care plan. On 9/15/16, at 10:40 a.m. the DON stated R21 was to be ambulated as directed by the care plan. R8 did not receive assistance with ambulation as directed the by care plan. R8's care plan edited on 7/19/16, indicated R8 had sustained a decline in ambulation related to chronic low back pain and dementia as evidenced by weakness, unsteady gate and history of falls. The staff were directed to ensure R8 was able to ambulate with assist of one staff to and from all meals and to and from the bathroom for toileting daily. R8 was not observed to receive assistance with ambulation before or after the meals observed on	F 282		

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F 282	Continued From page 21 9/13/16, at 1:13 p.m., on 9/14/16, at 7:00 a.m., on 9/14/16, at 9:40 a.m., and on 9/14/16, at 11:54 a.m. On 9/14/16, at 1:25 p.m. NA-C stated the facility did not have a staff member dedicated to a restorative program. She stated the direct care NA's were to complete the ambulation programs, however, they usually did not have time to complete the programs. On 9/14/16, at 1:30 p.m. NA-C and the director of nurses (DON) were observed to ambulate R8 utilizing a front wheeled walker. R8 was able to ambulate a total of 120 feet with one rest period. R8's gait was observed to be steady with the assistance of the staff members On 9/15/16, at 10:40 a.m. the DON stated R8 was to receive assistance with ambulation as directed by the care plan R21 did not receive assistance with the removal of facial hair as directed by the care plan. R21's care plan edited on 6/2/16, indicated R21 required assist with bathing, dressing and grooming. On 9/13/16, at 9:30 a.m. R21's chin was observed to have approximately 1/4 inch to 1/2 inch long gray and black chin hairs. At 1:30 p.m. the facial hairs remained.	F 282		

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F 282	Continued From page 22 On 9/14/16, at 8:35 a.m. R21 continued to have chin hairs on both side of her chin. On 9/14/16, at 10:14 a.m. NA-C verified R21 was in need of shaving. On 9/14/16, at 12:13 p.m. R21 was observed seated in the dining room. R21's chin hairs contained to be present. At 12:14 p.m. licensed practical nurse (LPN)-A verified R21's facial hair was in need of shaving. On 9/15/16, at 8:12 a.m. R21 was observed eating her breakfast in the dining room. R21 continued to be in need of a shave. RN-B confirmed R21 was in need of a shave. On 9/15/16, at 8:40 a.m. RN-A stated the residents were to be assisted with grooming as needed and as directed by the care plan. Personal grooming included shaving female residents. R22's facial hair was not removed as directed by the care plan. R22's current electronic care plan printed and provided by the facility on 9/15/16, indicated R22 would be clean and groomed neatly, daily. The plan directed staff to shave R22's face as needed. The care plan also directed staff to monitor behavior/mood every shift and to document any increased agitation, verbal or physical aggression or anxiety.	F 282		

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R22's nursing progress notes on 9/12/16 and 9/13/16 did not reflect behaviors with morning cares or refusals of care.

On 9/12/16, at 5:36 p.m. R22 was observed seated at the dining room table. R22 had gray and black chin hair which measured approximately ¼ inch long.

On 9/13/16, at 8:22 a.m. R22 was seated at the dining room table. R22's facial hair had not been removed or trimmed.

On 9/13/16, at 1:30 p.m. NA-D stated she had seen R22's facial hair this morning and confirmed it needed to be shaved. NA-D stated she had thought the razor had been taken to the shower room to be cleaned therefore NA-D was unable to shave R22. NA-D stated residents were shaved when staff noticed they were getting a little hairy, or on their bath days. NA-D further explained R22 would sometimes not allow staff to shave her, but then staff would try again later, and if she refused twice then staff were supposed to tell the nurse. NA-D stated if residents do not have their own razors or if they don't work the staff were to use disposable razors and report to the social worker to notify family to bring in another one.

On 9/13/16, at 3:26 p.m. LPN-C stated she had observed R22's facial hair and remarked the facial hair needed to be removed. LPN-C reported the razor was in the resident's drawer so she had removed R22's facial hair in which R22 had tolerated without behaviors. LPN-C explained R22 had a history of combative behaviors during activities of daily living, but had a medication increase last month and R22 was better now.

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F 282	Continued From page 24 On 9/15/16, at 9:50 a.m. the DON stated the expectation was for the NA's to report to the nurse any cares that they were not able to complete and re-approach the resident. The DON also indicated if cares were not provided due to a residents behavior, the behavior should be documented. R22 was not provided turning and repositioning and toileting assistance as directed by the care plan. R22's current electronic care plan printed and provided by the facility on 9/15/16, indicated R22 was not able to change positions independently and required staff assistance for proper positioning due to dementia. The plan directed staff to assist R22 to reposition in bed every two hours, use the ceiling lift and assist of two staff for all transfers. In addition, the care plan indicated R22 was incontinent of both bowel and bladder and directed staff to check for incontinence every 2 hours. R22's nursing assistant Assignment sheet dated 9/10/16, indicated R22's incontinent product was to be checked and changed every two hours. On 9/14/16, from 6:55 a.m. until 9:33 a.m. R22 was continuously observed. -At 6:55 a.m. R22 was dressed and nicely groomed seated in her wheelchair at the dining room table. -At 8:25 a.m. R22 had finished eating breakfast.	F 282		

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F 282	Continued From page 25 -At 8:41 a.m. R22 was removed from the dining room and assisted to the adjacent room for an activity scheduled to start at 9:00 a.m. -At 9:00 a.m. the activity started and ended at 9:12 a.m. -At 9:13 a.m. R22 was assisted by activity staff back to a dining room table. -At 9:33 a.m. NA-E took R22 to her room, NA-F entered the room and both used a mechanical lift, hoisted up R22 and removed R22's incontinent product while R22 was suspended in the air, over her bed. The incontinent product was completely saturated, however R22's clothing was dry. During the observation R22 did not make any major position changes that would relieve pressure from bony prominences. On 9/14/16, at 9:41 a.m. NA-F explained the incontinent product was removed while R22 was in the air was because R22 did not like to be turned back and forth in bed and would often times become combative. When asked " What time did you get R22 out of bed this morning?" NA-F indicated around 6:00-630 a.m. NA-F stated R22 was supposed to be repositioned and toileted every 2 hours however, right after R22 had finished her breakfast she went to an activity that started within two minutes of R22's arrival and that was not enough time to reposition/toilet R22 before the activity. NA-F stated she had been told they were not to remove residents from activities for repositioning and toileting cares. On 9/15/16, the DON stated the expectation of staff was to follow the care plan and their assignment sheets. The DON confirmed the residents should not be taken away from activities	F 282		

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F 282	Continued From page 26 for repositioning and incontinence care if it could be avoided rather resident cares should be performed to accommodate the resident's activity schedule and geared towards individual resident's needs and those needs needed to be assessed. The DON reported all the residents in the facility had an every two hour toileting and repositioning schedule and verfied the schedules were individualized for each resident.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement rehabilitation/restorative services related to ambulation and range of motion in order to improve and/or maintain ambulation and range of motion abilities for 3 of 3 residents (R8, R21, R1) who required restorative services which was not provided. Findings include: R8 did not receive assistance with ambulation or range of motion, as directed.	F 311	KHS goal is to provide restorative services by qualified persons in accordance with the resident's plan of care. R8 will receive ROM and or ambulation services as appropriate and directed by the plan of care. R8 restorative plan was reviewed/revised and care plan updated accordingly. R21 will receive ROM and or ambulation services as appropriate and directed by the plan of care. R21 restorative plan was reviewed/revised and care plan updated accordingly. R1 will receive ROM and or ambulation services as appropriate and directed by the plan of care. R1 restorative plan was reviewed/revised and care plan updated accordingly.	10/21/16

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F 311	Continued From page 27 R8's annual Minimum Data Set (MDS) dated 8/1/16, indicated R8 was diagnosed with dementia, chronic low back pain and congestive heart failure. The MDS indicated R8 required limited assistance of one for bed mobility, transfers and ambulation. The MDS indicated R8 did not have functional limitation in range of motion. R8's physical therapy (PT) note dated 12/4/15, indicated R8 had plateaued in her progress with physical therapy. R8 was unable to independently ambulate with a front wheeled walker. It also indicated R8 participated in seated strengthening exercises including knee extension, hip flexion, resisted knee flexion, ankle range of motion and three pound weights for upper extremity strengthening. R8's clinical record lacked documentation which identified a formal functional maintenance program had been established by the PT. A second PT note dated 2/12/16, indicated R8 was unsteady with transfers and ambulation and required assistance to complete these tasks. She had no limitation in her functional range motion in her upper and lower extremities. The note indicated R8 believed she was more capable in activities of daily living than she was due to dementia. R8's care plan edited on 7/19/16, indicated R8 had sustained a decline in ambulation related to chronic low back pain and dementia as evidenced by generalized weakness, unsteady gait and history of falls. The goal of the care plan was to	F 311	Staff caring for R1, R8 and R21 were re-educated on their restorative plans of care. All other resident's restorative plans of care were reviewed and updated accordingly. Staff will be assigned to walk to dine and ROM exercises accordingly. A binder has been developed with a list of those needing assist with their Restorative programs. NAR staff are asked to document completion in the binder with oversight from LPN staff to ensure completion. DON or designee will conduct random observational audits to ensure plans of care related to restorative programs are being followed. 5 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 311	Continued From page 28 ensure R8 was able to ambulate with a walker, with assist of one staff to and from all meals and to and from the bathroom for toileting daily. The plan of care did not address an upper or lower extremity range of motion program. On 9/13/16, at 12:40 p.m. R8 was observed sleeping in her wheelchair in the dining room. -At 1:13 p.m. nursing assistant (NA)-G was observed to wheel R8 out of the dining room to the nurses station. NA-G was not observed to assist R8 with ambulation. -At 1:50 p.m. NA-D assisted R8 to the television/lobby area and assisted R8 to transfer from the wheelchair into a recliner. R8 was not ambulated. -At 2:45 p.m. R8 was assisted to transfer from the recliner back to the wheelchair and was wheeled into the restroom. At no time was R8 observed to receive assistance with ambulation. On 9/14/16, at 7:00 a.m. R8 was observed sleeping in the dining room in her wheelchair. -At 7:51 a.m. NA-C wheeled R8 up to her dining room table. R8 was able to feed herself the meal. -At 9:36 a.m. NA-A wheeled R8 into the resident restroom by the nurses station. R8 was observed to be able to stand and transfer to the toilet utilizing the bathroom grab bars. -At 9:40 a.m. R8 was cued to stand, as NA-A provided assistance with perineal cares. R8 then transferred back into the wheelchair and was wheeled back into the lobby area. On 9/14/16, at 11:47 a.m. NA-A stated R8 was	F 311		

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F 311	Continued From page 29 not on a restorative program at this time. On 9/14/16, at 11:54 a.m. the activity director was observed to wheel R8 from the activity room to the dining room. At no time was R8 offered to ambulate. On 9/14/16, at 1:25 p.m. NA-C stated the facility did not have a staff member dedicated to a restorative program. She stated the direct care NA's were to complete the ambulation programs, however, they usually did not have time to complete the programs. Review of the Point of Care History report from 6/1/16 - 9/14/16, revealed the following information: June 2016, R8 had ambulated two times, 50 feet and 75 feet. July 2016, R8 had ambulated one time for a total of 50 feet August 2016, R8 had ambulated three times ranging from 100 feet to 300 feet September 2016, R8 had not ambulated. The Point of Care electronic record did not indicate R8 was receiving a range of motion program. On 9/14/16, at 1:30 p.m. NA-C and the director of nurses (DON) were observed to ambulate R8 utilizing a front wheeled walker. R8 was able to ambulate a total of 120 feet with one rest period. R8's gait was observed to be steady with the	F 311		

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F 311	Continued From page 30 assistance of the staff members. On 9/15/16, at 9:45 a.m. the physical therapist stated R8 was to be on a range of motion program to maintain her functional mobility and she was also to be on an ambulation program. She stated the facility had recently changed from paper records to computerized records therefore she was no longer providing the facility with a written functional maintenance program to be completed by the restorative nursing program or direct care NA's following the discontinuation of therapy services. She stated the information would have been passed on to the nursing staff verbally and they were to complete the programs. Review of R8's clinical record lacked indication of a formal ROM program being established after PT had been discontinued on 12/4/15. On 9/15/16, at 10:24 a.m. R8 was observed seated in a wheelchair in the dining room. R8 was able to lift her arms and extend shoulders, elbows, wrists and hands without limitation. On 9/15/16, at 10:30 a.m. NA-F stated she did not do a range of motion program with R8 but did not have difficulty assisting R8 with dressing. On 9/15/16, at 10:40 a.m. the DON stated R8 was to receive assistance with ambulation as directed by the care plan and the range of motion program was to be reviewed for further clarification. She explained the facility had	F 311		

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F 311	Continued From page 31 changed electronic record system in 8/2016, however, when this occurred, the nursing assistants had not been trained on how to document the restorative program in the new electronic record. R21 did not receive assistance with ambulation and range of motion as directed. R21's annual MDS dated 8/4/16, indicated R21's diagnoses included dementia, depression and a gait disorder due to muscle weakness. The MDS indicated R21 required extensive assistance of two staff for bed mobility, transfers and ambulation. The MDS indicated R21 did not have limitations in range of motion. R21's Falls Care Area Assessment (CAA) dated 8/4/16, indicated R21 was unstable on her feet without the assistance of staff and a walker. R21 did not ambulate unless accompanied by staff. R21 utilized a wheelchair for mobility in the facility. R21's physical therapy Progress Note dated 12/4/15, indicated R21 was able to ambulate but did become short of breath and required rest periods. R21 utilized a three pound weight for upper extremity active range of motion and lower extremity strengthening. She had plateaued in her progress but was able to ambulate 250-300 feet with a front wheeled walker and assistance.	F 311		

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R21's care plan edited on 8/12/16, indicated R21 had sustained a decline in ambulation related to advanced dementia as evidenced by generalized weakness. The plan directed R21 to ambulate to meals twice a day with assistance of one or two staff as needed. The care plan did not direct the staff members to complete range of motion services.

Review of the Point of Care History report from 6/1/16 - 9/14/16, revealed the following information:

-June 2016, R21 had ambulated 25 of the 60 opportunities. The distance ambulated ranged from 25 to 300 feet.
-July 2016, R21 had ambulated 27 of the 62 opportunities. The distance ambulated ranged from 50 to 300 feet.
-August 2016, R21 had ambulated 12 of the 62 opportunities. The distance ambulated ranged from 25 to 100 feet.
-September 2016, R21 had not ambulated.

The Point of Care electronic record did not indicate R21 was receiving a range of motion program.

On 9/13/16, at 12:38 p.m. R21 was observed seated in a wheelchair in the dining room. R21 had eaten the meal independently. At 1:14 p.m. R21 was wheeled out of the dining room by NA-H. R21 was not offered assistance to ambulate.

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On 9/14/16, at 7:00 a.m. R21 was observed to wheel herself up and down the hallways of the facility. At 7:52 a.m. NA-C wheeled R21 into the dining room. At 9:02 a.m. R21 had finished her meal and wheeled herself out of the dining room and onto the nursing unit. At no time before or after the meal were the staff members observed to offer R21 the opportunity to ambulate.

On 9/14/16, at 10:12 a.m. NA-C assisted R21 to the restroom by wheeling her into the restroom. R21 was observed to be able to stand and transfer onto the toilet with the use of the bathroom grab bars and physical assistance of one staff. At 10:15 a.m. R21 transferred off of the toilet with assist of one. R21 was not observed to be offered to ambulate.

On 9/14/16, at 11:47 a.m. activity aide-(AA)-A stated R21 was not on a restorative program. She stated some residents received range of motion through the activity program provided by the activity staff, however, R21 was not identified to participate in the activity range of motion program.

On 9/14/16, at 11:55 a.m. R21 was observed to be wheeled from the activity room to the dining room by the activity director. At no time was R21 offered to ambulate to the dining room for the noon meal.
-At 11:56 a.m. licensed practical nurse (LPN)-A stated the nursing assistants were to complete the restorative program. She stated registered nurse (RN)-A was in charge of overseeing the

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F 311	Continued From page 34 restorative program. On 9/14/16, at 12:00 p.m. RN-A stated she was not in charge of the restorative program. RN-A stated the DON was in charge. On 9/14/16, at 12:10 p.m. the DON stated the facility did not have a staff member assigned to complete the restorative program. She added the facility had changed to a new electronic computer system in August 2016, however the nursing assistants had not been trained on how to documented the restorative program. She confirmed the restorative program had not been completed as directed. R21 had not received assistance with ambulation as directed and a formal range of motion program had not been established for R21. On 9/14/15, at 1:05 p.m. R21 wheeled herself out of the dining room. At no time were the staff observed to assist R21 to ambulate. On 9/14/16, at 1:20 p.m. NA-C, NA-F and NA-G were observed to ambulate R21 a total of 100 feet with one rest period. The DON observed R21 ambulate. On 9/15/16, at 8:45 a.m. RN-A stated R21 was to participate in an ambulation program daily. She stated RN-C was in charge of the range of motion programs, however, a ROM program had not been established at this time.	F 311		

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F 311	Continued From page 35 On 9/15/16, at 9:45 a.m. PT-A stated when a resident was discontinued from therapy, a verbal functional maintenance program was established and direction would have been given to the nursing staff. She stated if upper extremity range of motion had been provided by therapy, then a range of motion program would have been included in the functional range of motion program for the nursing staff to continue. On 9/15/16, at 10:27 a.m. NA-F stated she does complete range of motion at times with residents during cares, however, had not utilized weights or other equipment during range of motion services. On 9/15/16, at 10:30 a.m. R21 was observed resting in bed. The DON directed R21 to lift her arms and touch her head. R21 was not observed to have a limitations in her upper extremities. R1 did not receive ambulation services as directed by the care plan. R1's annual MDS dated 7/2/16, indicated R1's diagnoses included Alzheimer's disease, arthritis and osteoarthritis. The MDS also indicated R1 had cognitive impairment, required extensive assist with bed mobility, transfers, dressing, toilet use, personal hygiene, and was ambulatory.	F 311		

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F 311	Continued From page 36 R1's Falls Care Area Assessment (CAA) dated 7/15/16, indicated R1's ambulation was not steady and required two staff assistance. R1's care plan, reviewed 7/21/16, indicated R1 had a decline in ambulation related to advanced Alzheimer's disease as evidenced by generalized muscle weakness and unsteady gait. R1 was to be walked to/from all meals, 10 minutes twice a day for a minimum of 15 minutes total with assist of two staff. On 9/13/16, during the breakfast meal, from 8:00 a.m. until 9:30 a.m. R1 was not ambulated to or from the dining room. On 9/14/16, R1 was during the breakfast and lunch meals. R1 was not offered nor provided ambulation assistance before and after both meals. The current nursing assistant assignment sheet indicated R1 was to be ambulated to meals. On 9/14/16, at 10:15 a.m. NA-A indicated R1 had not been ambulated to and from meals on 9/14/16, and stated it was too busy for the staff to always get the ambulation done. NA-A and NA-B both verified there was no place to document a resident's restorative program in their new computer program.	F 311		

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F 311	Continued From page 37 On 9/15/16, at 8:35 a.m. the DON verified ambulation assistance was not provided as directed by the care plan. The undated, Restorative Nursing Program Policy directed the staff to provide a restorative nursing program which focused on achieving and/or maintain optimal function in accordance with the comprehensive assessment and care plan. The program was to be overseen by a restorative coordinator/registered nurse who was to supervise the program, evaluate the progress of the residents and oversee the nursing assistants providing care to the residents. The restorative programs were to include range of motion services and ambulation as directed.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed provide grooming assistance in order to remove female facial hair for 2 of 2 residents (R21, R22) observed to have long facial hair and required staff assistance to remove. In addition, the facility failed to provide incontinence care for 1 of 1 resident (R22) who was incontinent and dependent of staff for	F 312	KHS goal is to provide the necessary grooming our resident's require. Care plans for R21 and R22 were reviewed and revised as needed for grooming (shaving) needs. R22 had a Urinary Incontinence assessment competed and care plan was revised accordingly.	10/21/16

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F 312	Continued From page 38 incontinence cares. Findings include: R21's annual Minimum Data Set (MDS) dated 8/4/16, indicated R21's diagnoses included dementia and a gait disorder due to muscle weakness. The MDS indicated R21 required extensive assistance of one staff for all activities of daily living which included grooming. R21's care plan edited on 6/2/16, indicated R21 required assistance with bathing, dressing and grooming. On 9/13/16, at 9:30 a.m. R21's chin was observed to have 1/4 to 1/2 inch long gray and black facial hairs. At 1:30 p.m. R21 continued to have the long chin hair. On 9/14/16, at 8:35 a.m. R21 continued to have the long facial hairs on both side of her chin. On 9/14/16, at 10:14 a.m. nursing assistant (NA)-C stated she had assisted R21 with morning cares and had noticed that her facial hairs were in need of shaving. On 9/14/16, at 12:13 p.m. R21 was observed seated in the dining room. R21's facial hair contained to be present. At 12:14 p.m. licensed practical nurse (LPN)-A verified R21's chin was in	F 312	Staff caring for R21 and R22 were re-educated on their plans of care related to shaving and the need to report to the nurse if the resident refuses assistance with shaving. Staff were also educated on R22 toileting plan. Residents that require assistance with shaving will be reassessed for their staff assistance needs and or the need for proper shaving equipment. An RN will be designated to work with frontline staff to ensure proper shaving equipment is available and that assist is being offered if needed. The facility will develop a list for the admit packet of recommended items to encourage new residents both male and female to bring their own razor of choice if needed. The facility will keep bic razors and female trimmers on hand if needed. LSW will assist all residents needing assist with shaving to obtain their own appropriate razor if able. DON or designee will conduct random audits of residents that require assistance with shaving to ensure assistance is provided per the residents care plan, and to ensure grooming is being provided in a timely manner according to the resident's assessment and plan of care. Audits will be conducted 5 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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need of shaving.

On 9/15/16, at 8:12 a.m. R21 was observed eating her breakfast in the dining room. R21 continued to be in need of a shave. At this time, registered nurse (RN)-B confirmed R21 was in need of a shave as long facial hair was observed.

On 9/15/16, at 8:40 a.m. RN-A stated the residents were to be assisted with grooming as needed. She stated this included shaving female residents.

R22's quarterly MDS dated 6/9/16, indicated R22 had severe cognitive impairment and required extensive assistance from two staff members for personal hygiene needs.

R22's current electronic care plan printed and provided by the facility on 9/15/16, indicated R22 would be clean and groomed daily. The plan directed staff to shave R22's face, as needed. The care plan also directed staff to monitor behavior/mood every shift and to document any increased agitation, verbal or physical aggression or anxiety.

R22's nursing progress notes on 9/12/16, and 9/13/16, did not reflect behaviors with morning cares or refusals of care.

On 9/12/16, at 5:36 p.m. R22 was observed seated at the dining room table. R22 was noted to have grey and black facial hair approximately ¼ inch long.

On 9/13/16, at 8:22 a.m. R22 was observed

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seated at the dining room table. R22 continued to have the long facial hair.

On 9/13/16, at 1:30 p.m. NA-D stated she had seen the facial hair this morning and confirmed it needed to be removed. NA-D stated she thought the razor had been taken down to the shower room to be cleaned therefore had not shaved R22. NA-D stated residents were shaved when staff noticed notice they were getting a little hairy, or on their bath days. NA-D stated R22 would sometimes not allow staff to shave her, but then staff would try again later, and if she refused twice, the staff were supposed to tell the nurse. NA-D stated if residents do not have their own razors or if they did not work, the staff were to use disposable razors and report to the social worker to notify family to bring in another one.

On 9/13/16, at 3:26 p.m. licensed practical nurse (LPN)-C stated she had observed R22 facial hair and remarked the facial hair needed to be removed. LPN-C reported the razor was in the resident's drawer and had removed R22's facial hair in which R22 had tolerated without behaviors. LPN-C explained R22 had a history of combative behaviors during activities of daily living, but had a medication increase last month and R22 was better now.

On 9/15/16, at 9:50 a.m. the DON stated the expectation was for the NA's to report to the nurse any cares they were not able to complete and to re-approach a resident, if needed. The DON indicated if behaviors prevented the cares, it should be documented.

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The Shaving policy dated 12/30/16, indicated if shaving was required, this was to become part of the resident's routine grooming. In addition, the resident's personal preferences was to be reflective on the care plan.

R22 was not provided timely incontinence care as directed by the care plan.

R22's physician signed order report dated 6/29/16, indicated R22 was diagnosed with dementia with behavioral disturbance, Alzheimer's, and stage three chronic kidney disease.

R22's quarterly MDS dated 6/9/16, indicated R22 had severely impaired cognition, was dependent on two staff members for transfers and toileting and was always incontinent of urine and bowel.

R22's Urinary Incontinence CAA dated 3/10/16, indicated indicated R22's risk factors for urinary incontinence included psychological or psychiatric problems, use of antipsychotic and antidepressant medications, and urinary urgency with need for full assistance in toileting. The CAA indicated R22 had functional incontinence (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating) and was totally incontinent of bladder. The CAA also indicated R22's care plan was reviewed and updated. A corresponding progress note summarizing the annual assessment dated 3/7/16, indicated R22's skin was in good condition with slight redness of the buttocks. R22 was incontinent of bowel and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 312	Continued From page 42 bladder and would occasionally void on the toilet. R22's clinical record lacked evidence of a comprehensive bladder assessment and an assessment to identify risk for infection related to total incontinence. R22's current care plan provided by the facility on 9/15/16, indicated R22 was not able to change positions independently, required a ceiling mechanical lift for transfers with two staff assistance, and was incontinent of both bowel and bladder. The care plan directed staff to check R22 for incontinence every two hours. The care plan lacked identification of the type of urinary incontinence and lacked identification of risk of infections related to total incontinence. R22's nursing assistant Assignment sheet dated 9/10/16, directed staff to check and change R22's incontinent product every two hours. On 9/14/16, from 6:55 a.m. until 9:33 a.m. R22 was continuously observed. -At 6:55 a.m. R22 was dressed and nicely groomed sitting in her wheelchair at the dining room table. -At 8:25 a.m. At this finished eating breakfast. R22 had remained seated in the wheelchair throughout the meal. -At 8:41 a.m. R22 was removed from the dining room and assisted to the adjacent room for an activity scheduled to start at 9:00 a.m. -At 9:00 a.m. the activity started and ended at 9:12 a.m. -At 9:13 a.m. R22 was assisted by activity staff back to a dining room table. -At 9:33 a.m. nursing assistant (NA)-E took R22 to her room, NA-F entered the room, used a mechanical lift and removed R22's incontinent	F 312		

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F 312	Continued From page 43	F 312		

garment while R22 was suspended in the air by the ceiling mechanical lift. The incontinent garment was completely saturated with urine, however R22's clothing was dry.

On 9/14/16, at 9:41 a.m. NA-F explained the incontinent garment was removed while R22 was suspended in the air via the mechanical lift because R22 did not like to be turned back and forth in bed while changing the incontinent product and would often times become combative. NA-F confirmed R22 was assisted out of bed this morning at around 6:00-630 a.m. NA-F stated R22 was supposed to be toileted every 2 hours, however, right after R22 had finished her breakfast she went to an activity that started within two minutes of R22's arrival and that was not enough time to toilet her before the activity had started. NA-F stated she had been told they were not to remove residents from activities for toileting cares.

On 9/15/16, at 8:31 a.m. registered nurse (RN)-A stated bladder assessments were completed annually not quarterly and was not aware of when voiding diaries were completed to determine individual toileting schedules. RN-A stated she was unaware if assessments were completed to determine risk for urinary tract infections.

On 9/15/16, at 9:55 a.m. the director of nursing (DON), stated the expectation of staff was to follow the care plan and their assignment sheets. The DON explained residents should not be taken away from activities for incontinence care if it could be avoided and resident cares should be performed to accommodate the resident's activity schedule and geared towards individual resident's needs and those needs need to be assessed.

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F 312	Continued From page 44 The DON reported all the residents in the facility had a 2-hour toileting schedule therefore the schedules were not individualized for each resident. The DON stated the annual assessments would identify the toileting schedules however, could change on a quarterly assessment. The DON explained the urinary tract infection risk assessment is a separate assessment that should be completed. On 9/15/16, at 10:14 a.m. the RN consultant stated she did not know the type of incontinence needed to be on the care plan, just the CAA. On 9/15/16 facility provided an untitled and undated directional flow sheet for completing quarterly and comprehensive bowel and bladder continence assessments. The flow sheet directed staff to identify or assess the following on comprehensive assessments: current continence status, any history of urinary tract infections and risk factors, food and fluid intake, urinary stimulants, voiding pattern, and type of urinary incontinence. The flow sheet directed staff to identify or assess the following on quarterly assessments: current continence status, any UTI since last bowel and bladder assessment, risk factors for UTI ' s and interventions to prevent chronic UTI's, changes since last assessment, and if goals had been met. The facility policy Toileting Residents dated 4/13, included "Residents are toileted safely on a routine basis in a timely manner according to their individualized plan of care."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		10/21/16

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F 314	Continued From page 45 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance in order to minimize the development of pressure ulcers for 2 of 4 residents (R6, R22) identified at risk for pressure ulcers and required staff assistance to turn and reposition. Findings include: R6 was at risk for pressure ulcers and did not receive timely assistance with repositioning as directed by the care plan. R6's annual Minimum Data Set (MDS) dated 6/22/16, indicated R6 had diagnoses including dementia and arthritis. The assessment revealed R63 was totally dependent upon staff for transfers, and required extensive assist from staff for bed mobility, dressing, toileting and was not able to ambulate. Also, the assessment indicated R6 was at risk for the development of pressure ulcers.	F 314	KHS goal is to provide turning and repositioning assistance in order to minimize the development of pressure injuries. R6 and R22 were assessed for repositioning needs and plan of care was revised accordingly. All residents with moderate to high risk for skin breakdown have the potential to be affected. These residents will be reviewed to ensure appropriate repositioning interventions have been implemented. NAR staff were re-educated on the pressure injury prevention as it relates to their role and responsibility. NAR care sheets will be updated with the appropriate repositioning plan for each resident. NAR staff will be re-educated on the resident's repositioning, NAR staff will be asked to prepare shift to shift communication to pass along to the next shift for repositioning times as applicable. Further, a special RN meeting will be held on 10/20/16 to provide specific education	

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F 314	Continued From page 46 R6's Pressure Ulcer Care Area Assessment (CAA), dated 7/1/16, indicated R6 was at risk for developing pressure ulcers due to his immobility, cognitive loss, and poor nutrition. The CAA indicated he required a schedule for turning. R6's annual Skin Assessment dated 6/22/16, indicated R6's Braden Assessment (an assessment to determine skin condition related to pressure ulcers) dated 6/22/16, revealed R6 was at high risk for skin breakdown due to decreased ability to communicate needs to be repositioned, did not walk, and required repositioning by staff. The assessment indicated R6 had a history of a healed pressure ulcer to buttocks and required staff assistance with repositioning every two hours. R6's care plan, reviewed 6/30/16, indicated R6 was to be repositioned by staff every two hours. On 9/14/16, from 6:50 a.m. until 10:00 a.m. R6 was continuously observed. -At 6:50 a.m. R6 was observed the dining room, seated in a wheelchair. -At 7:45 a.m. the speech therapist (ST) wheeled R6 out of dining room and to his room for therapy. -At 8:10 a.m. the ST wheeled R6 back into the dining room. -At 8:30 a.m. R6 was eating breakfast. -At 8:35 a.m. the assistant administrator wheeled R6 out of dining room to the nurse's desk. -At 8:45 a.m. R6 remained seated in the wheelchair while attending an exercise activity.	F 314	to RN's who complete care planning for repositioning. RN staff to also address individualized care planning each individual resident as it may not fit the standard. Will cover the assessment process required to complete individualized care planning also. DON or designee will conduct random observational audits to ensure repositioning programs are being implemented per the residents care plan, and to ensure repositioning is being provided in a timely manner according to the resident's assessment and plan of care. Audits will be conducted for both moderate and high risk residents 4 x weekly for 4 weeks with one audit per week on PM's and one audit on Nights, then 2 x weekly for 4 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 314	Continued From page 47 -At 9:15 a.m. R6 wheeled himself into his bathroom to shave. -At 9:45 a.m. licensed practical nurse (LPN)-A completed a dressing change to R6's foot while R6 remained seated in the wheelchair. -At 9:50 a.m. NA-A wheeled R6 into the large bathroom by the nurse's desk. Both NA-A and NA-C assisted R6 onto the toilet via a ceiling mechanical lift. The North #1 Toileting and Repositioning sheet for 9/14/16, revealed R6 had last been repositioned at 6:30 a.m. a total of three hours and 20 minutes earlier. On 9/14/16, at 10:15 a.m. NA-A confirmed per the toileting and repositioning sheet which was located in the service room, that R6 was last repositioned at 6:30 a.m. NA-A stated R6 was to repositioned every two hours. On 9/15/16, at 8:10 a.m. the director of nursing (DON) verified R6's care plan was correct and R6 was at risk for pressure related ulcers and stated R6 should have been repositioned every two hours as directed. R22 was at risk for pressure ulcers and did not receive timely repositioning as directed by the care plan. R22's physician signed order report dated 6/29/16, indicated R22 was diagnosed with dementia with behavioral disturbance, Alzheimer's disease, and stage three chronic kidney disease.	F 314		

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R22's quarterly MDS dated 6/9/16, indicated R22 had severely impaired cognition, was dependent on two staff for transfers and toileting, was at risk for developing pressure ulcers and was on a turning and repositioning schedule.

R22's Pressure Ulcer CAA 3/10/16, indicated R22's risk factors for pressure ulcers included: always incontinent of bowel and bladder, dependent on staff for mobility, confined to bed or chair, cognitive loss, poor nutrition, pain, depression, required special mattress or cushion to reduce or relieve pressure, and required regular schedule for turning. The CAA indicated R22's care plan was reviewed and updated. A corresponding progress note summarizing the annual assessment dated 3/7/16 included, "Skin is in good condition with slight redness of the buttocks. "

R22's current electronic care plan printed and provided by the facility on 9/15/16, indicated R22 was not able to change positions independently and was at risk for impaired skin integrity. The care plan directed staff to turn/reposition R22 every two hours.

R22's Tissue Tolerance-Repositioning Observation assessment dated 5/12/16, directed staff to turn/reposition R22 every 4 hours when lying down and every 3.5 hours when sitting up. The schedule conflicted with the care plan directive.

R22's Braden Scale for prediction of pressure sore risk dated 6/7/16, indicated R22 had moderate risk for pressure ulcers. The assessment did not identify the

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turning/repositioning program as an intervention; this conflicted with the 6/9/16 MDS that indicated need for turning/repositioning program.

R22's nursing assistant Assignment sheet dated 9/10/16, directed staff to check and change R22's incontinent product every two hours, however, lacked a turning and repositioning directive.

On 9/14/15, from 6:55 a.m. until 9:33 a.m. R22 was continuously observed.
-At 6:55 a.m. R22 was dressed and nicely groomed seated in her wheelchair at the dining room table.
-At 8:25 a.m. R22 had finished eating breakfast.
-At 8:41 a.m. R22 was removed from the dining room and assisted to the adjacent room for an activity scheduled to start at 9:00 a.m.
-At 9:00 a.m. the activity started and had ended at 9:12 a.m.
-At 9:13 a.m. R22 was assisted by activity staff back to a dining room table.
-At 9:33 a.m. NA-E assisted R22 to her room, NA-F entered the room. NA-E and NA-F hoisted R22 up via a mechanical lift. While suspended in the air, the NA's had removed R22's incontinent product. Throughout the observation, R22 did not independently make any major position changes that would relieve pressure from bony prominences.

On 9/14/16, at 9:41 a.m. NA-F explained the incontinent garment was removed while R22 was suspended in the air because R22 did not like to be turned back and forth while in bed and would often times become combative. NA-F stated she had assisted R22 up between 6-6:30 a.m. (approximately three hours earlier). NA-F stated R22 was supposed to be repositioned every two

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hours however, right after R22 had finished her breakfast she went to an activity that started within two minutes of R22's arrival and that was not enough time to reposition R22 before the activity. NA-F stated she had been told they were not to remove residents from activities for repositioning.

On 9/15/16, at 9:55 a.m. the DON stated the expectation was for staff to follow the care plan and their assignment sheets. The DON confirmed residents were not be taken away from activities for repositioning if it could be avoided and that resident cares should be performed to accommodate the resident's activity schedule and geared towards individual resident's needs and those needs needed to be assessed. The DON reported all the residents in the facility had a two-hour repositioning schedule and verified those schedules were not individualized for each residents assessed need.

Facility policy Tissue Tolerance-Repositioning Observation Policy and Procedure not dated included, "After the observation is complete, the Tissue Tolerance/Repositioning observations should be reviewed and an overall individualized repositioning schedule will be determined for both the lying and sitting positions. The nursing Assistant Care sheets and the Care Plan should be updated with the lying and sitting intervals and communicated to the nursing staff."

Facility policy Skin Ulcer Protocol dated 11/1/15 included, "Residents will not develop pressure sores/skin ulcers unless it is clinically unavoidable and appropriate care and services will be provided to prevent, treat, and monitor progress of all healing ulcer(s). "The policy defined a

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F 314	Continued From page 51 pressure ulcer as, "any lesion caused by unrelieved pressure resulting in damage to the underlying tissue(s), generally found over bony prominences and contributed to by shearing, friction, and/or moisture."	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and 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 REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete comprehensive bladder assessments to identify individual needs and failed to provide timely toileting assistance for 3 of 4 residents (R21, R8, R1) in the sample who were incontinent of bladder, required staff assistance to toilet and also lacked individualized toileting plans. Findings include: R21's annual Minimum Data Set (MDS) dated 8/4/16, indicated R21's diagnoses included dementia, depression and a gait disorder due to muscle weakness. The MDS indicated R21 was	F 315	It is the goal of KHS to provide appropriate toileting assistance according to an individualized toileting assessment. R1, R8, and R21 had a comprehensive bladder assessment completed with toileting care plan developed accordingly. All residents that are frequently incontinent and require assistance with toileting have the potential to be affected. These residents will be reassessed to ensure appropriate toileting plans are in place. NAR staff were re-educated on toileting plans as it relates to their role and responsibility. NAR staff will be re-educated on the	10/21/16

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F 315	Continued From page 52 frequently incontinent of bladder and required extensive assistance of one staff for bed mobility, transfers and ambulation. R21's Urinary Incontinence Care Area Assessment (CAA) dated 8/5/16, indicated R21 was incontinent of bladder and directed staff to toilet R21 every two hours and as needed. A Progress Note dated 5/15/16, indicated R21 was almost always continent of bowel but had episodes of urinary incontinency. R21 was able to ask to use the toilet as she was voiding. R21's clinical record did not contain a comprehensive bladder assessment. R21's care plan edited on 6/2/16, indicated R21 was incontinent of bladder and directed the staff to toilet and assist with toileting every two hours. On 9/13/16, at 12:38 p.m. R21 was observed seated in a wheelchair in the dining room. -At 1:15 p.m. nursing assistant (NA)-H wheeled R21 from the dining room to the lobby / TV room. -At 2:00 p.m. R21 was wheeled from the lounge area to the activity room by activity aide (AA)-A. -At 2:46 p.m. AA-A wheeled R21 back to the dining room. -At 3:22 p.m. NA.-I assisted R21 from the dining room to the resident restroom by the nurses station. -At 3:27 p.m. R21 was observed to stand with physical assistance of NA-I. R21 was observed	F 315	resident's toileting, NAR staff will be asked to prepare shift to shift communication to pass along to the next shift for toileting times as applicable. Further, a special RN meeting will be held on 10/20/16 to provide specific education to RN's who complete care planning for bowel and bladder care. RN staff to also address individualized care planning each individual resident as it may not fit the standard. Will cover the assessment process required to complete individualized care planning also. DON or designee will conduct random observational audits to ensure toileting programs are being implemented per the residents care plan, and to ensure toileting is being provided in a timely manner according to the resident's assessment and plan of care. Audits will be conducted for residents needing assistance with toileting 4 x weekly for 4 weeks with one audit per week on PM's and one audit on Nights, then 2 x weekly for 4 weeks, then monthly thereafter. DON or designee will audit bladder assessments 1 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then monthly thereafter to ensure assessment completion and accuracy. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 315	Continued From page 53 to have been incontinent of urine. On 9/13/16, at 3:28 p.m. NA-I stated she had no way of knowing when the last time R21 had been assisted to the restroom. She stated she had started her shift at 2:30 p.m. and the day shift had not reported when they had last assisted R21. On 9/13/16, at 3:30 p.m. NA-D stated she had assisted R21 transfer to the restroom at 11:30 a.m. a total of 4 hours earlier. On 9/14/16, from 6:59 a.m. to 10:15 a.m. R21 was continuously observed. -At 6:59 a.m. R21 was observed seated in a wheelchair wheeling herself up and down the hallways with her feet. -At 7:52 a.m. NA-C wheeled R21 to the dining room table. -At 9:02 a.m. R21 finished her meal and began wheeling herself out of the dining room and down the north hallway. -At 10:03 a.m. R21 wheeled herself into the dining room for morning coffee. At no time during the observation was R21 assisted or offered toileting assistance. On 9/14/16, at 10:11 a.m. NA-C stated she had assisted R21 out of bed at 6:30 a.m. and had not assisted her with cares since that time. A total of 3 hours and 45 minutes. On 9/14/16, at 10:15 a.m. NA-C wheeled R21 from the dining room to the restroom by the	F 315		

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F 315	Continued From page 54	F 315		

nurses station. R21 was observed to be continent of urine and also voided on the toilet.

On 9/14/16, at 12:20 p.m. the director of nursing (DON) stated R21 was to receive assistance with toileting every two hours. She verified she was aware the MDS assessments, CAA's and and care plans did not match. She stated she was working on a system to ensure the assessments, care plans and care provided to the residents would be consistent according the resident need.

R8's annual MDS dated 8/1/16, identified R8 with diagnoses of dementia, chronic low back pain and congestive heart failure. The MDS indicated R8 required limited assistance of one for bed mobility, transfers and toileting. The MDS indicated R8 was occasionally incontinent of bladder.

R8's Urinary incontinence CAA dated 8/1/16, indicated R8 was frequently incontinent of urine likely due to increase in dementia. R8 did know when she needed to use the bathroom but required cues to toilet at times and assistance from the staff to manage incontinent products.

R8's clinical record lacked a comprehensive bladder assessment.

R8's care plan edited on 6/8/15, indicated R8 was occasionally incontinent of bladder and utilized incontinent products. The plan directed the staff

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	245542	A. BUILDING _____ B. WING _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(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
F 315	Continued From page 55 to assist with toileting every two hours. On 9/14/16, from 7:00 a.m. to 9:30 a.m. R8 was continuously observed. -At 7:00 a.m. R8 was in the dining room, seated in a wheelchair, asleep. -At 7:51 a.m. NA- C wheeled R8 to the breakfast table. -At 8:06 a.m. R8 was served breakfast. R8 was observed to eat the meal independently. -At 9:20 a.m. R8 finished the meal and fell asleep at the dining room table. -At 9:35 a.m. NA-A wheeled R8 to the resident restroom by the nurses station. NA-A assisted R8 from the wheelchair to the toilet. R8 was observed to be incontinent of urine. NA-A assisted R8 to change her incontinent product. On 9/14/16, at 9:42 a.m. NA-A stated she did not know when the last time R8 had been assisted to the toilet. On 9/14/16, at 9:43 a.m. NA-G stated R8 was last assisted to toilet at 6:00 a.m. NA-G verified R8 had not been assisted with toileting for three hours and 35 minutes. On 9/15/16, at 10:40 a.m. the DON confirmed R8 was dependent upon staff for toileting needs. The DON verified R8 was to receive toileting assistance every two hours as directed by the care plan. R1's annual MDS dated 7/2/16, indicated R1's diagnoses included Alzheimer's disease, arthritis,	F 315		

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F 315	Continued From page 56	F 315		

and osteoarthritis. The MDS also indicated R1 had cognitive impairment, required extensive assist with bed mobility, transfers, dressing, toilet use, personal hygiene and was incontinent of bladder.

R1's Urinary Incontinence CAA dated 7/15/16, indicated R1's incontinence was likely related to Alzheimer's disease process and R1 required assistance from staff for toileting related to balance and gait issues.

R1's clinical record lacked a comprehensive bladder assessment.

R1's annual skin assessment dated 7/4/16, indicated R1 was to be toileted every 2 hours.

R1's care plan, reviewed 7/21/16, indicated R1 was to assisted to the toilet every 2 hours.

On 9/14/16, at 6:50 a.m. R1 was observed in the dining room in her wheelchair watching TV.
-At 8:15 a.m. NA-A and NA-B transferred R1 into a dining room chair at the dining table for breakfast.
-At 8:52 a.m. NA-A and NA-B transferred R1 back into her wheelchair and proceeded to wheel R1 to the activity area.
-At 10:05 a.m. NA-A wheeled R1 into the bathroom. NA-A and NA-B transferred R1 on to the toilet. R1 was noted to have been incontinent of bladder.
-At 10:10 a.m. NA-A wheeled R1 into the dining

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F 315	Continued From page 57 room and activity area. -At 11:55 a.m. R1 was wheeled out of activities by NA-A and wheeled into the dining room. -At 12:10 p.m. NA-A and NA-B transferred R1 from the wheelchair and into a dining room chair. NA-A fed R1 her noon meal. -At 12:30 p.m. NA-A continued to feed R1. -At 12:55 p.m. R1 was assisted to the bathroom. R1's brief was noted to be wet with urine. 10:10 a.m..to 12:55 p.m. On 9/14/16, at 10:15 a.m. NA-A indicated R1 was to be taken to the bathroom every 2 hours and stated the last time R1 was assisted to the toilet was at 5:45 a.m. when staff had gotten R1 up for the day. NA-A confirmed R1 was not assisted with toileting for four hours and 20 minutes and then again two hours and 50 minutes after that. On 9/15/16, at 8:35 a.m. the DON verified R1 was to be taken to the bathroom every two hours as directed by the care plan. The facility policy Toileting Residents dated 4/13, included "Residents are toileted safely on a routine basis in a timely manner according to their individualized plan of care."	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		10/21/16

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F 332	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure it was free of medication error rate of 5% or less. A medication error rate of 8% was observed during 2 of 6 (R11,R20) medication pass observations. Findings include: On 9/14/16, at 7:15 a.m. licensed practical nurse (LPN)-A was observed to administer medications to R11. LPN-A administered Azathioprine 50 milligrams (mg), aspirin 81 mg, Budesonide 3 mg (steroid medication), Carvedilol 3.125 mg (treats heart failure), Cervite Senior tablet (vitamin), Clopidogrel 75 mg (inhibits blood clots), Losartan 25 mg (treats hypertension), and Tramadol 50 mg (pain medication). At the time of administration, R11 was seated at the dining room table drinking coffee while waiting for breakfast to be served. R11's physician orders, print date 9/15/16, directed staff to give Azathioprine 50 mg - two and one half tablets. The order also included "Special instructions" for this medication administration which read "to be given after meals." On 9/14/16, at 9:55 a.m. LPN-A confirmed she had given the Azathioprine on 9/14/16, at 7:15 a.m. prior to R11 eating his meal. LPN-A	F 332	Medications were reviewed to ensure MD order matches MAR. Medications had been transcribed from a previous EMR to a new EMR and was not accurate according to the resident's wishes. Nursing staff were re-educated on ensuring the special instructions that accompany the medication order in the computer system matches the physician order. DON or designee will conduct random audits of medication orders 3 x weekly for 2 weeks, 2 x weekly for 2 weeks, then weekly for 2 weeks, then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 332	Continued From page 59	F 332		

confirmed the medication should have been given after meals. LPN-A stated she did not see the directive to give after meals on the medication card.

On 9/14/16, at 11:30 a.m. LPN-B was observed to administer medications to R20. LPN-A administered Potassium Chloride 10 mEq two tablets (potassium replacement), and Furosemide (diuretic) 20 mg. R20 was sitting on her bed at the time of administration.

R20's physician order sheet, print date 9/14/16, directed staff to give Potassium Chloride 10 mEq two tablets by mouth three times per day. The order also included "Special instructions" which directed staff to give the medication with food.

On 9/14/16, at 11:38 a.m. LPN-B verified R20's Potassium Chloride medication dispensing card indicated to give with food. LPN-B verified R20's Potassium Chloride medication was not given with food. LPN-B stated she did not see that directive when she dished the medications and that R20's medication card did not match the electronic medication administration record (MAR) because the MAR had not indicated the medication was to be given with food. LPN-B stated she would notify the registered nurse about the discrepancy.

On 9/14/16, at 12:15 p.m. The director of nursing confirmed she expected staff to follow the current standards of practice and physician orders for administering medications. The DON verified

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F 332	Continued From page 60 when a medication was to be given after meals or with food it should be given at the correct time. The facility policy, Medication Administration amended 4/6/15, directed staff to check the medication label against the MAR for accuracy, and to check the MAR, note stop or hold orders, verify resident medication, dose, time and route.	F 332		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		10/21/16

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F 334	Continued From page 61 The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by:	F 334		

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F 334	Continued From page 62 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R20,R22,R37) were offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: The CDC has a "Pneumococcal Vaccination Timing for Adults" algorithm dated 11/30/2015. The pneumococcal conjugate vaccine (PCV13) protects against 13 types of pneumococcal bacteria. PCV13 is recommended for all adults 65 years or older. The pneumococcal polysaccharide vaccine (PPSV23) protects 23 types of pneumococcal bacteria. It is recommended for all adults 65 years or older. PPSV23 is also recommended for adults 19-64 years old who smoke cigarettes or who have asthma. R20 was admitted to the facility on 11/22/15. R20's immunization record lacked documentation R20 received or was offered the PPV23 or the PCV13 immunizations. R22 was admitted to the facility on 4/16/12. R22's facility immunization record lacked documentation of historical Pneumovax immunizations. The director of nursing (DON) reported R22 received a Pneumovax immunization on 9/21/08 according to the Minnesota Immunization Information site (MICC, internet website data base where Minnesotans immunizations records can be accessed.) the website did not reflect which Pneumovax had been administered. R20's facility record lacked documentation R22 received or was offered the PPV23 or the PCV13 immunizations.	F 334	KHS goal is to offer and provide pneumococcal vaccines as recommended by the updated Center for Disease Control (CDC) guidelines. DON reviewed all residents regarding the type of pneumococcal vaccine the residents have had in the past to determine which type of pneumococcal vaccine is due. Residents will be offered and provided the appropriate pneumococcal vaccine per their choice. Audits of new admissions will be conducted by the DON or designee to determine the appropriate pneumococcal vaccine was offered and provided. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 334	Continued From page 63 R37 was admitted to the facility on 5/19/2014. R37's facility immunization record lacked documentation of historical Pneumovax immunizations. The DON reported R37 received PPV23 on 11/7/06 according the MIIC. The record lacked documentation R37 received or was offered the PCV13. During an interview on 9/15/16, at 12:45 p.m. the DON indicated she had started her position with the facility in April of this year and was aware of the Pneumococcal vaccination recommendations by CDC. The DON explained the facility immunization records were not up to date, and she needed to reference the Minnesota Immunization Information in order to obtain some of the dates of the residents' immunizations. The DON stated she had identified the pneumococcal immunizations schedules were not up to date and was working on a plan for correction. Facility policy Immunization Policy with no date included the following; "all residents will be offered vaccinations based on the Centers for Disease Control (CDC) recommendations and physicians orders," "The resident's immunization history will be documented and maintained on the immunization record for each resident individually. The record will be kept in the resident chart. Unknown vaccination histories will be reviewed with the attending physician," "Pneumococcal vaccines will be offered to each resident according to the current recommendations from the CDC on admission to the facility: For adults age 65 or older who have not received a pneumococcal vaccine, give the Pneumococcal Conjugate Vaccine (PCV13) Prevnar, first. After PCV13 is administered, wait 6-12 months to give the Pneumococcal	F 334		

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F 334	Continued From page 64 Polysaccharide Vaccine (PPSV23).	F 334		

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K 000	INITIAL COMMENTS 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Littlefork Medical Center C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2016

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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By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Littlefork Medical Center C & NC was constructed at 2 different times. In 1978 the original building was constructed to the east of the 1964 hospital, is 1-story without a basement and is Type II (000) construction. In 1992 1-story additions were construction to the north and east wings and are Type II(000) construction. The facility is divided into 3 smoke zones by 30 minute fire barriers and separated from the old hospital building with a 2-hour fire barrier.

The building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in all sleeping rooms, at the cross corridor smoke barrier doors and in common areas installed in accordance with NFPA 72 "The

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K 000	Continued From page 2 National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 45 beds and had a census of 44 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 44 of 44 residents as well as an undetermined number of staff, and visitors to the facility. Findings include:	K 052	KHS goal is to ensure that all fire alarm maintenance testing is documented as required and verify tests with the digital alarm communicator transmitter (DACT). The maintenance staff responsible for fire alarm testing and verification were educated on the process and its importance. Maintenance staff have developed a checklist form that identifies each step in the process when the fire alarm system is tested. This checklist will be reviewed and signed by the administrator each month following the test to serve as an audit.	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**912 MAIN STREET** **LITTLEFORK, MN 56653**

(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
K 052	Continued From page 3 On facility tour between 11:00 a.m. to 2:00 p.m. on 09/13/2016, during a review of all available fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 1 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052	Audit results will be brought to the QAPI committee for review and further recommendations.	