MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 17, 2015

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

Subject: Woodlyn Heights Healthcare Center - IDR
Provider # 245320
Project # S5320025

Dear Ms. Donahue:

This is in response to your e-mail request of August 28, 2015, in regard to your request of change from an independent informal dispute resolution (IIDR) to an informal dispute resolution (IDR) for the federal deficiency at tag F310 issued pursuant to the survey event 1RUJ11, completed on July 2, 2015.

The information presented with your letter as well as in a face to face meeting with facility staff and MDH staff on September 24, 2015, the CMS 2567 dated July 2, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F310 (G) §483.25(a)(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to --
(i) Bathe, dress, and groom;
(ii) Transfer and ambulate;
(iii) Toilet;
(iv) Eat; and
(v) Use speech, language, or other functional communication systems.

Summary of the facility's reason for IDR of this tag.

The facility alleges there is insufficient evidence to support a deficient practice at F310 as no harm occurred to R42. The deficient practice should be removed. The facility alleges all appropriate care and services were provided to R42 to improve and/or maintain a high quality of care and quality of life. R42 was admitted following a fall resulting in a fractured humerus. R42 had significant pain management issues related to the fracture as physicians were unable to repair the fracture surgically. Due to ongoing pain management issues, facility staff secured an orthopedic surgeon to repair the fracture. The surgery was successful in repair of the fracture and improving pain management, however, it exacerbated her congestive heart failure. Due to the significant issues with edema, R42 had a significant leg wound occur due to the inability of her skin to stretch far enough with the edema. R42 had weight bearing restrictions on the fractured arm as well as the leg following the rupture of her skin. The facility alleges that due to the numerous complications resulting from a fall at home prior to admission to the facility, the facility did everything possible to improve and maintain R42's ability to ambulate.

Summary of facts.

R42 is a 102 year old woman admitted to the facility on 2/6/15, following a hospital stay for a fall at home resulting in a fractured humerus. The hospital determined the fracture could not be surgically repaired. R42 struggled with significant pain management issues due to the fractured humerus. The facility found an orthopedic surgeon to repair the fracture and R42 was admitted for surgery on 3/12/15. R42 returned to the facility 3/15/15. R42 began therapy on 3/16/15. Following surgery, R42 experienced an exacerbation of her congestive heart failure (CHF) including significant edema, respiratory issues and lab abnormalities. R42 had regular physician intervention with regular adjustments to her medical plan. R42 developed an open area to her buttock during this time. R42 plateaued in her therapy due to limited weight bearing on the right upper extremity. As a result, on 4/10/15, R42 was discharged from physical therapy (PT). R42 did not meet goals due to the multiple complications from the humerus fracture. PT provided education to nursing staff on transfers and limited ambulation status. On 4/21/15, R42 sustained a 19 cm"Y" shaped laceration to her left lower extremity when she bumped her shin on the wheelchair footrest. This laceration was complicated due to her extensive lower extremity edema. The laceration was closed in the emergency room with 22 sutures. R42 was discharged from the emergency room with limitations on activity.

R42 ambulated 300 feet or more while in an assisted living prior to the fractured humerus. R42 had multiple complications following the fracture. There is little evidence in the medical record identifying R42's mobility status and implementation of her mobility program. There is little evidence in the medical record concerning R42's level of participation in the ambulation program and any of her choices made related to utilizing the mobility program. There was no evidence in the record concerning resident education related to the risks and benefits of refusing to implement the recommended mobility program.

Summary of findings

This is a valid deficiency, however, the severity will be reduced. As a result of the scope and severity change, the deficient practice will now be placed under a different requirement. The following requirement is not met:

F311 §483.25(a)(2) 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.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Christine Campbell, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-302-6151 Fax: 218-723-2359

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Susanne Reuss, Metro Team A Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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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. A complaint investigation was conducted to investigate complaint #H5320040 and #H5320042. The complaints were not substantiated. 11/16/15 Revised CMS-2567 as a result of an Informal Dispute Resolution.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to actively resolve personal grievances expressed for 2 of 2 residents (R9, R77) regarding call light wait times.	F 166	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	8/11/15

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

Electronically Signed | 07/24/2015

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 166	Continued From page 1 Findings include: The facility failed to resolve a grievance regarding call light wait times, expressed by R9's family. On 6/29/15, at 5:21 p.m., a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable period of time. F-B reported they had observed R9 wait over an hour for help, and stated "some aides don't care and don't come to button calls." F-B added, R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie talk system used to alert them of call lights. F-B reported visiting R9 daily, at various times, and on various shifts and had observed extended call light times during visits. On 7/2/15, at 9:08 a.m., F-B reported she had expressed concerns about call light wait times at care conferences, had spoken with the administrator and other staff about call light concerns. F-B reported at one point, after waiting an hour and a half for R9 to get assistance she "went off on them and told them that was not acceptable." F-B added "they tell us to tell them when this happens, but nothing ever changes" and "they claim they have a system, but I said clearly it is not working." F-B reported these concerns were brought up about 2-3 months ago and a facility response was never received. A review of a Feedback Form dated 5/11/15, revealed F-B had expressed concerns about R9 waiting an unacceptable time for call light response. The facility noted they had educated	F 166	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#9 and R#77, patterns of call light response times were assessed to determine care times, medication schedule, and activity preferences for reducing the need to call and wait for assistance. b) All staff will receive re-edcuation on responding to call lights in a timely manner and turning off the call light when entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with concerns from resident/family council meetings. d) The facility's interdisciplinary team (IDT) will audit via resident interviews, observations and/or call logs. Any call light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by the IDT for 3 months. f) DNS/Designee is responsible for completion.	

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F 166	Continued From page 2 the nursing assistants and were working on distributing more portable walkies to alert staff of call light alerts. However, there was no indication this measure had resolved the grievance, as there was no monitoring of the measure, as the facility was unable to provide documentation of monitoring. A review of call light times, for June 11 - 24, 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11/15; on the morning and afternoon of 6/13/15; on the afternoon and evening of 6/15/15; on the afternoon of 6/16 and 6/18/15; and on the mornings of 6/17, 6/18 and 6/24/15. R9's most recent quarterly Minimum Data Set [MDS] dated 5/5/15, revealed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15, quarterly MDS further revealed R9 was moderately cognitively impaired, and was frequently incontinent of urine and bowel. The facility failed to follow up on concerns related to call light wait times for R77. On 7/1/15, at 3:15 p.m. R77 reported waiting several minutes for assistance on a recent night for repositioning and to get a window closed, when his room was cold. R77 reported he had spoken with the administrator, current and former director of nursing about call light wait times. On 7/2/15, at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on	F 166		

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F 166	Continued From page 3 the bed. R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented. A review of the call light log dated 6/21 to 6/27/15, revealed R77 waited over half an hour for assistance on the following dates: the mornings of 6/21,6/22, 6/26 and 6/27; and twice on the mornings of 6/22 and 6/23/15. A review of R77's annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, and was totally dependent on staff for transfers. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkie talkies. The facility had investigated call light wait times from the previous week after surveyor brought the concerns to their attention, but could not reach a conclusion. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should	F 166		

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F 166	Continued From page 4 have closely monitored call lights until resolved.	F 166		
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 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.	F 225		8/11/15

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F 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete an accurate and thorough investigation related to an injury of unknown origin, and failed to report accurate details of the injury to the designated State agency (SA) for 1 of 3 residents (R43), reviewed for allegations of abuse/neglect or mistreatment. Findings include: A facility incident report indicated that on 4/21/15 at 11:00 a.m. R43 had sustained an injury of unknown origin identified as: "skin tear transfer from w/c (wheel chair) to bed. Significant gash required ED (emergency department) transfer." Documentation indicated that although the facility had reported to the State agency, they had not clearly identified the severity of the resident's wound. The following had been reported to the State Agency on 4/21/15 (no time of day specified): "Nursing assistant reported finding a skin tear on the lower left leg of the resident. Resident is unable to identify how the injury occurred. Resident was sent into the ER (emergency room) for evaluation and treatment. Internal investigation pending." On 4/27/15 (no time of day specified), the facility had submitted to the State Agency their investigative findings: "Resident obtained a skin tear on the outer aspect of her left lower leg. [Nursing assistant] (NA)-C] and [NA-D] were assisting the resident with transfer to bed from	F 225	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43, internal investigation revealed laceration likely caused by the mechanism of the foot rest on the wheelchair. b) Facility will complete and report accurate and thorough investigations in accordance with State law (including to the State survey and certification agencies)within 5 working days of the incident. If alleged violation is verified appropriate corrective action will be taken. c) Staff will receive re-education on completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incident to ensure an accurate and thorough investigation is completed. This	

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F 225	Continued From page 6 resident wheelchair. Nursing assistants deny any complication with transfer from wheelchair to bed. Resident denies knowing how she obtained skin tear. Resident had worked with therapy earlier in the day. Therapy staff denies any complications with therapy session. Resident remains confused and unable to give any insight as to how the skin tear was acquired. Resident was sent into the ER to be evaluated, and returned to the facility same day with sutures closing the skin tear. After internal investigation, it appears as though the resident may have caught her leg on the release mechanism on the leg of her wheelchair, as the skin tear and wheelchair leg release align with height of injury. Upon completion of internal investigation no abuse or neglect was substantiated." Although the facility had reported the injury of unknown origin as a skin tear to the State agency, review of the emergency room documentation dated 4/21/15, identified and described the injury of unknown origin as; "left lower leg lacerations. Pt (patient) has a 10-11 cm (centimeter) y shaped laceration to left lower lateral leg that is gaping and has fat globals [sic] evident. Unsure of what happen [sic] that caused laceration, no falls, possibility a piece on the wheelchair. The wound was closed using one layer suture closure: skin layer: 22 sutures placed, stitch type; simple interrupted, suture: 3-0 prolene. The laceration was Y- shaped, deep, under a lot of tension, and measured 19 cm total length. The laceration was difficult to repair since the skin was very thin and there was a large amount of tension. Every effort was made to approximate the wound edges." The discharge information from the ER identified the treated diagnosis as a 19 cm complex leg laceration.	F 225	information will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. e) The ED/Designee is responsible for completion	

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F 225	Continued From page 7 Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as cognitively intact with dependence on staff for assistance with activities of daily living (ADL's). During an interview with family member (F)-A on 7/1/15, at 8:00 a.m., F-A discussed an incident that occurred to R43 and expressed concern that staff did not inform F-A of the outcome of the investigation as to how the incident occurred. F-A expressed seeing a large 7 inch plate size area of blood and fat on the floor before R43 was transported by paramedics to the emergency room. F-A stated, "It looked like a pile of afterbirth on the floor." Furthermore, F-A explained R43 complained when the two aides stood her up, 'my leg really itches, what is the matter with it?' The pants leg was then pulled up and revealed the huge "blow out" according to F-A. According to F-A, the emergency room physician had speculated that the calf may have been pinched in the wheel chair and when the pressure of the pinching was relieved, the skin just "blew apart". When interviewed on 7/2/15 at 8:25 a.m., the administrator acknowledged having been verbally informed of the incident on 4/21/15, although stated he had not seen the incident report until the file had been discovered in the former director of nursing's (DON) office after she'd left their employment. The administrator stated that upon finding the report, it had been signed by the assistant director of nursing (ADON) and himself on 6/1/15. He verified there had been no further clarifying documentation or investigation conducted since and acknowledged that the former DON had not followed through with the investigation. There had been no statements from	F 225		

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F 225	Continued From page 8 the resident who was cognitively intact, no witness statements, no environment review, and no education and/or training to prevent recurrence of the incident. The facility's current Policy and Procedure titled, Vulnerable Adult Abuse/Neglect Prevention, included under section #9; "Injuries of Unknown Source/Unexplained Injuries. An injury should be classified as an injury of unkown source" when both the following conditions are met: Federal: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and b.The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vuylnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. State: If a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained." The policy further included information for Submitting the Report, listed under Internal Reporting procedures; "1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following a review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, placed under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the	F 225		

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F 225	Continued From page 9 protection of the resident 3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident". The policy directed staff to consider investigating and interviewing the following: Interviews of staff, Resident interviews, Environmental review, Resident health status, Behavior review, Medication review.	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 document review and interview, the facility failed to implement their policies for investigation related to an injury of unknown origin for 1 of 3 residents (R43), reviewed for allegations of abuse/neglect or mistreatment. Findings include: The facility's current Policy and Procedure titled, Vulnerable Adult Abuse/Neglect Prevention, included under section #9; "Injuries of Unknown Source/Unexplained Injuries. An injury should be classified as an injury of unkown source" when both the following conditions are met: Federal: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and	F 226	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43, internal investigation revealed laceration likely caused by the mechanism of the foot rest on the wheelchair.	8/11/15

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	245320	A. BUILDING _____ B. WING _____	07/02/2015

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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 226	Continued From page 10 b.The injury is suspiciouys because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vuylnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. State: If a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained." The policy further included information for Submitting the Report, listed under Internal Reporting procedures; "1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following a review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, placed under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the protection of the resident 3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident". The policy directed staff to consider investigating and interviewing the following: Interviews of staff, Resident interviews, Environmental review, Resident health status, Behavior review, Medication review. A facility incident report indicated that on 4/21/15 at 11:00 a.m. R43 had sustained an injury of unknown origin identified as: "skin tear transfer	F 226	b) Facility will complete and report accurate and thorough investigations in accordance with State law (including to the State survey and certification agencies)within 5 working days of the incident. If alleged violation is verified appropriate corrective action will be taken. c) Staff will receive re-education on completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incident to ensure an accurate and thorough investigation is completed. This information will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. e) The ED/Designee is responsible for completion	

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F 226	Continued From page 11 from w/c (wheel chair) to bed. Significant gash required ED (emergency department) transfer." Documentation indicated that although the facility had reported to the State agency, they had not accurately described the severity of the resident's wound. The following had been reported to the State Agency on 4/21/15 (no time of day specified): "Nursing assistant reported finding a skin tear on the lower left leg of the resident. Resident is unable to identify how the injury occurred. Resident was sent into the ER (emergency room) for evaluation and treatment. Internal investigation pending." On 4/27/15 (no time of day specified), the facility had submitted to the State Agency their investigative findings: "Resident obtained a skin tear on the outer aspect of her left lower leg. [Nursing assistant] (NA)-C] and [NA-D] were assisting the resident with transfer to bed from resident wheelchair. Nursing assistants deny any complication with transfer from wheelchair to bed. Resident denies knowing how she obtained skin tear. Resident had worked with therapy earlier in the day. Therapy staff denies any complications with therapy session. Resident remains confused and unable to give any insight as to how the skin tear was acquired. Resident was sent into the ER to be evaluated, and returned to the facility same day with sutures closing the skin tear. After internal investigation, it appears as though the resident may have caught her leg on the release mechanism on the leg of her wheelchair, as the skin tear and wheelchair leg release align with height of injury. Upon completion of internal investigation no abuse or neglect was substantiated."	F 226		

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F 226	Continued From page 12 Although the facility had reported the injury of unknown origin as a skin tear to the State agency, review of the emergency room documentation dated 4/21/15, identified and described the injury of unknown origin as more significant; "left lower leg lacerations. Pt (patient) has a 10-11 cm (centimeter) y shaped laceration to left lower lateral leg that is gaping and has fat globals [sic] evident. Unsure of what happen [sic] that caused laceration, no falls, possibility a piece on the wheelchair. The wound was closed using one layer suture closure: skin layer: 22 sutures placed, stitch type; simple interrupted, suture: 3-0 prolene. The laceration was Y- shaped, deep, under a lot of tension, and measured 19 cm total length. The laceration was difficult to repair since the skin was very thin and there was a large amount of tension. Every effort was made to approximate the wound edges." The discharge information from the ER identified the treated diagnosis as a 19 cm complex leg laceration. Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as cognitively intact with dependence on staff for assistance with activities of daily living (ADL's). During an interview with family member (F)-A on 7/1/15, at 8:00 a.m., F-A discussed an incident that occurred to R43 and expressed concern that staff did not inform F-A of the outcome of the investigation as to how the incident occurred. F-A expressed seeing a large 7 inch plate size area of blood and fat on the floor before R43 was transported by paramedics to the emergency room. F-A stated, "It looked like a pile of afterbirth on the floor." Furthermore, F-A explained R43 complained when the two aides stood her up, 'my leg really itches, what is the matter with it?' The	F 226		

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F 226	Continued From page 13 pants leg was then pulled up and revealed the huge "blow out" according to F-A. According to F-A, the emergency room physician had speculated that the calf may have been pinched in the wheel chair and when the pressure of the pinching was relieved, the skin just "blew apart". When interviewed on 7/2/15 at 8:25 a.m., the administrator acknowledged having been verbally informed of the incident on 4/21/15, although stated he had not seen the incident report until the file had been discovered in the former director of nursing's (DON) office after she'd left their employ. The administrator stated that upon finding the report, it had been signed by the assistant director of nursing (ADON) and himself on 6/1/15. He verified there had been no further clarifying documentation or investigation conducted since and acknowledged that the former DON had not followed through with the investigation. There had been no statements from the resident who was cognitively intact, no witness statements, no environmental review, and no education and/or training to prevent recurrence of the incident.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by:	F 244		8/11/15

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F 244	Continued From page 14 Based on interview and document review, the facility failed to follow up on family and resident council concerns regarding call light wait times which had the potential to impact 6 of 6 residents reviewed; R77, R9, R11, R52, R115 and R64. Findings include: Review of Resident Council Meeting Agenda and Minutes, dated 4/21/15, revealed in new business "Long call light time" with an action plan "new shipment of radios was received, we are in the process of marking them and getting them distributed to staff" This should help with the call light wait times." On 5/19/15 the Resident Council Meeting Agenda and Minutes noted in Old Business "Long call light time" with the action "New shipment of radios was received, will be addressed in nurse and nurse's aide meetings, and education of staff on spot audits." Resolution and date included "Ongoing monitoring of the situation and education of staff. Continuing date for resolution. Addressed in meetings on 5/20 and 5/21." The minutes did not include comments on resident satisfaction with call light wait time progress. The Resident Council Meeting Agenda and Minutes for 6/23/15, did not include follow up on call light wait times, despite being noted as requiring continued action and monitoring on the 5/19/15 minutes. Family Townhall Minutes, dated 5/21/15, revealed "2. Nurses/aide relationship-seems to be no teamwork. They aren't responding to residents if they aren't on their wing or if it's not their job. 3. Timely call light times, long call light time during meal times. 4. Aides hide on the weekend, is there an incentive for them to not do so?" The Action Plan noted "Customer Service rounds are	F 244	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#77, R#9, R#11, R#52, R#115 & R#64 patterns of call light response times were assessed to determine care times, medication schedule, and activity preferences for reducing the need to call and wait for assistance. b) All staff will receive re-edcuation on responding to call lights in a timely manner and turning off the call light when entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with concerns from resident/family council meetings. d) The facility's interdisciplinary team (IDT) will audit via resident interviews, observations and/or call logs. Any call light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality	

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F 244	Continued From page 15 there to help, will continue to re-educate staff on teamwork. Upcoming staff training scheduled for June. 3. Continuing to work on this issue, again, Customer Service rounds are being done and that helps with this issue, and we have a new radio system in place to communicate more effectively. 4. There is a Manager on Duty on the weekends. Encouraged to speak with them, as well as fill out a feedback form. Talk with the nurses if this occurs in the PM [evening/afternoon]. New radio that were recently purchased should help as well." There were no more recent meetings for Family Townhall. The facility failed to follow up on concerns related to call light wait times for R77. A review of R77 annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use and personal hygiene and was totally dependent on staff for transfers. On 7/1/15 at 3:15 p.m. R77 reported he waited several minutes for assistance on a recent night to help move his legs back on the bed and to get a window closed when his room was cold. R77 reported he had spoke with the administrator, current and former director of nursing about call light wait times. On 7/2/15 at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed, R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. A review of call light log for 6/21/15 to 6/27/15 revealed R77 waited over a half hour for assistance on the following instances: morning of	F 244	assurance meeting and reviewed by the IDT for 3 months. f) DNS/Designee is responsible for completion.	

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F 244	Continued From page 16 6/21, morning of 6/22, twice on the morning of 6/23, morning of 6/26 and morning of 6/27. The facility failed to follow up on call light wait time concerns for R9. R9's most recent quarterly Minimum Data Set [MDS], dated 5/5/15 further confirmed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15 quarterly MDS further revealed she was moderately cognitively impaired and was frequently incontinent of urine and bowel. On 6/29/15 at 5:21 p.m. a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable time. F-B reported she had observed R9 wait over an hour for help. F-B reported "some aides don't care and don't come to button calls." F-B added R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie system used to alert them of call lights. F-B reported extended call light times occurred on various shifts and had occurred on a daily basis. F-B reported she visited R9 daily at various times. A review of call light times, for June 11th through June 24th 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11, morning and afternoon on 6/13, afternoon and evening on 6/15, afternoon of 6/16, morning of 6/17, morning of 6/18, afternoon of 6/18 and	F 244		

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F 244	Continued From page 17 morning of 6/24. The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light on, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of 6/21/15 and the afternoon of 6/27/15.	F 244		

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F 244	Continued From page 18 Review of R115's most recent admission MDS, dated 4/21/15, revealed R115 had severe cognitive impairment and required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. On 6/30/15, at 10:37 a.m. a family member of R115, (F)-C, reported she had put her call light on when R115 was in the bathroom and sometimes waited 30 minutes for staff to help. Review of R115's call light record for 6/21 to 6/27/15 revealed the following wait times were over 30 minutes: the evenings of 6/21 and 6/22/15; and the afternoons of 6/22, 6/23 and 6/26/15. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkies. The facility had investigated call light wait times from the previous week after surveyor brought the concern to the facility's attention, but could not reach a conclusion. Any additional follow up information from the resident council concerns was requested and the administrator reported there was nothing further. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. During an interview on 6/30/15, at 8:39 a.m. R64	F 244		

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F 244	Continued From page 19 who was cognitively intact, expressed frustration with attending resident council meetings because, while residents share how call lights are not being answered in a timely fashion the facility failed to adequately address the residents concern. R64 stated staff ignore the walkie talkies when they go off for a call light. R64 expressed personally seeing staff sleeping on the couches or playing cards at the table at 5:00 a.m. and turning off the call light beepers. R64 stated they had informed facility staff of these issues and knew call light issues had been discussed at several resident council meetings. R64 stated, "Going to the resident council meetings is a meet, eat, and retreat meeting, because things discussed do not change."	F 244		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the bathroom was free of odors and kept in a cleanable condition for 2 of 2 residents (R65, R51) reviewed for room odors. Findings include: When interviewed on 6/30/15, at 10:46 a.m. R65 stated an odor was noted in the bathroom, and "it really smells ripe in there." At this time a stale urine odor was noted in the bathroom.	F 253	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:	8/11/15

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F 253	Continued From page 20 On 7/2/15, at 11:05 a.m. the bathroom of R65 and R51 were noted to have a strong odor of stale urine. The director of environmental services [DES] reported the odor from the bathroom was a chronic issue. The DES stated housekeeping had informed him they clean the bathroom, and then the gentlemen in the room miss the toilet bowl when urinating. The DES reported the issue may be with the grout on the floor or the toilet. At this time the backsplash against the sink was coming away from the wall and the DES confirmed this finding. The 7 Step Daily Washroom Cleaning procedure, dated 1/1/2000, directed staff "1. Check Supplies.", "2. Empty Trash", 3. Dust Mop Floor", 4. Clean and Sanitize Sink and Tub", "5. Clean and Sanitize the Commode.", "6. Spot Clean Walls and/or Partitions" and "7. Damp Mop Floor."	F 253	a) With respect to R#51 and R#65, the bathroom has been thoroughly cleaned and back splash was repaired. b) Cleaning procedure has been reviewed and revised. c) Housekeeping staff will receive re-education on the cleaning procedures. d) Healthcare Services Manager/Designee will audit 3 resident rooms per week for 8 weeks to ensure cleanliness. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. f) ED/Designee is responsible for completion.	
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	F 280		8/11/15

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F 280	Continued From page 21 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. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to review and revise the care plan for 1 of 1 residents (R43) for ambulation and positioning and failed to revise the care plan for 1 of 1 resident (R69) for refusing weights. Findings include: R43's care plan was not updated to reflect a change for restorative nursing ambulation. R43's care plan dated, 2/18/15, directed staff for mobility "Limited physical mobility r/t (related to) right humeral arm fracture, advanced age, fall history and history of vertigo. Ambulation: Requires 2 staff assistance for mobility" R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R43 was discharged from physical therapy 4/10/15, with a notation on a form titled, Therapist Progress and Discharge Summary, to "ambulate 15 feet with L hall railing on even surfaces with care giver assistance. The long term goal read;	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43, a comprehensive assessment was completed. Care plan was updated to reflect current ambulation and repositioning care needs. b) With respect to R#69, care plan has been reviewed and revised to reflect refusal of cares. c) Licensed staff will receive re-education on reviewing and revision of the Care Plan. d) The DNS/Designee will audit 2 resident	

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	245320	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 22 ambulate x 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility)." Furthermore, the discharge summary read, "Training provided to some of the nursing staff." R43's plan of care also directed staff; "[R43] has potential for impairment to skin integrity and pressure ulcer development with actual pressure ulcer at this time r/t (related to) advanced age, fragile skin, incontinence, functional decline, oxygen dependency, edema, and requiring assistance with bed mobility, transfers, hygiene, and ambulation." The Intervention read, "Encourage reposition/position changes during Customer Service Rounds." There were no other directions related to positioning in the wheel chair on the plan of care, however, the treatment sheet directed staff to "Reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift. Start date 4/2/15." During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m.,	F 280	care plans per week for four weeks then 1 resident care plan per week for four weeks for ambulation, repositioning needs and refusal of care. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

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F 280	Continued From page 23 nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide	F 280		

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F 280	Continued From page 24 assignment sheet did not inform staff to change R43's position every half hour. R69 plan of care was not updated to include R69's refusal of care. Review of R69's medical record indicated a physician order for "daily am (morning) weights. Record in point click. Notify MD for wgt (weight) gain 3 lbs/24 hrs (3 pounds in 24 hours) 5 lbs/week or wgt exceeding 10 lbs from admission weight (414.4 lbs)." Review of the medication administration record (MAR) indicated R 69 refused to be weighed every day in June. Review of R69's May 2015 MAR indicated the resident refused to be weighed all but two days. Review of R69's physician order record indicated a physician order for the following "CPAP [continuous positive airway pressure (used to keep airways open, used by people who have breathing problems, such as sleep apnea)] on HS [hour of sleep] off AM: Heated humidifier, full facemask (not nasal mask) head gear, filters and tubing. Pressure 8 cm of H2O [water]. Length of need: Indefinite. Must wear nightly" Review of R69's June MAR indicated R69 refused the CPAP every day in June. When interviewed on 7/2/15, at 10:27 a.m. licensed practical nurse (LPN)-C stated R69 refused to get out of bed daily, refused daily weights, and refused to wear the CPAP at night. LPN-C verified R69's refusal of care was not on the plan of care, and should have been.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		8/11/15

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F 309	Continued From page 25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care, including a thorough nursing assessment, was provided for 1 of 1 resident (R55) who complained of not feeling well, and who expired unexpectedly the following day. Findings include: Review of Progress Notes revealed that R55 had been admitted to the facility 4/14/15, with admitting diagnoses that included: chronic airway obstruction, diabetes, heart failure, hypertension, bipolar disorder, and sleep apnea. A late entry Progress Note dated 4/26/15, included; "Shortly before 1000 this nurse found the resident unresponsive in his room without a pulse and not breathing. Prior to this time we took his vitals which were within normal limits. Vitals were taken due to him not feeling well over the previous night..." Review of the record lacked documentation of nursing assessment having been conducted including; recent vital signs, documentation of the resident's specific complaints when he was not feeling well, or any other documentation of a	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#55, the nurse responsbile for failing to document a change of condition is no longer employed at the facility. b) Licensed staff will receive re-edcuation on documenting a resident's change in condition. c) DNS/Designee will audit 2 resident records for change in condition per week for 4 weeks then 1 resident record per week for 4 weeks. d) Results of these audits will be	

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F 309	Continued From page 26 nursing assessment. There had been no nursing documentation in Progress Notes after 4/21/15. There was no documentation of temperature, pulse, or respiration after 4/18/15, and no blood pressure documentation after 4/24/15. There was only one oxygen saturation level documented and that had occurred on 4/16/15. An acute visit note from a nurse practitioner, dated 4/24/15, indicated the resident had been seen for "coarse breath sounds." R55 complained of not feeling well the night of 4/25/15 and expired unexpectedly on 4/26/15. When interviewed on 7/1/15, at 8:32 a.m. the director of nursing (DON) stated the nurse who cared for this resident no longer worked at the facility. At 9:00 a.m. the DON stated that no further documentation of assessment could be located regarding the events that occurred prior to R55's unexpected death.	F 309	documented in the facilty's quality assurance meeting and reviewed by IDT for 3 months. e) DNS/Designee is responsible for completion	
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 implement an ambulation program to improve or maintain a resident's ability to ambulate for 1 of 1 resident (R43) reviewed for ambulation. Findings include:	F 311		8/11/15

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F 311	Continued From page 27 R43 had been admitted from an assisted living facility on 2/6/15,following a fall and fracture of the right humerus (upper arm). According to interagency transfer documentation at the time of admission, R43 had been ambulating 300 feet at the assisted living, according to the therapy goals. A fourteen day minimum data set (MDS) assessment dated 2/20/15, R43 had not walked in the corridor during the seven day assessment period, and had walked in the bedroom only once. A thirty day MDS dated 3/6/15, indicated R43 had not walked in the hallway, but had walked in the bedroom twice during the 7 day assessment period. A review of the physical therapy documentation titled, Physical Therapy (PT) Plan of Care, dated 2/6/15, included; "Goal Ambulate 75 feet with narrow base quad cane on even surfaces with CGA (care giver assistance). Current level of functioning Ambulates 35 feet with narrow base quad cane on even surfaces with MIN (minimum) assist secondary to occasional LOB (loss of balance). Goal date 3/31/15." According to the PT progress notes, R43 had been independently ambulating 300 feet in the assisted living setting prior to the right humerus fracture secondary to a fall. R43 was discharged from PT on 4/10/15, and the PT Discharge Summary included; "Training provided to some of the nursing staff for gait program." The current level of function was identified as; "Ambulates 15 feet with L (left) hall railing on even surfaces with CGA, Some of the	F 311		

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F 311	Continued From page 28 nursing staff trained in walking with patient for FMP (full mobility potential) ." The physical therapy "Goal" included; "ambulate 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility) setting." During observations from 4:45 p.m.- 6:00 p.m. on 6/29/15, R43 was not offered assistance or encouragement to stand or walk. At 5:15 p.m., R43 was seated at the dining room table wearing gripper socks, with no foot pedals on the wheel chair. During an observation 7/1/15 from 7:00 a.m. until 7:30 a.m., R43 was seated in a wheel chair by a table near the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m., R43 was wheeled back to her bedroom. At 8:40 a.m. R43 was observed during a transfer. R43 was only able to tolerate standing for 30 seconds before stating, "that's enough!" R43 was then assisted to transfer to her bed with the assistance of one staff, nursing assistant (NA)-A. During the observation, NA-A verified at 8:40 a.m. that R43 had been transferred into the wheelchair at 6:30 a.m. without an encouragement/assistance to ambulate. NA-A stated R43 was not physically able to take any steps. NA-A stated she herself worked full time on the unit, but had not walked or attempted to walk R43 since admission/re-admission. Family member (F)-A was present during the transfer 7/1/15, at 8:40 a.m., and acknowledged that staff did not ambulate R43. F-A stated, "They stopped walking her." F-A further stated R43 had been independent in	F 311		

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F 311	Continued From page 29 the assisted living prior to the fractured right arm, and said she was afraid R43 would lose her ability to walk. During this conversation, R43 expressed a desire to be walked in hopes of returning to the assisted living. During an interview on 7/2/14, at 11:00 a.m., with NA-B, another full time staff, she stated she did not realize R43 was supposed to ambulate. During an interview with licensed practical nurse (LPN)-A on 7/2/15 at 11:30 a.m., she verified she was aware R43 could take steps, but did not know there was an ambulation program for R43. At that time, registered nurse (RN)-C was interviewed. RN-C stated she was the person who completed the MDS assessments. She stated R43 had been admitted as extensive assist of 2 staff for walking in the room, and verified R43 had walked in the hallway five of the seven observation days during an assessment review period (ARD) of 2/17/15. Additional record review revealed R43 had been discharged to the hospital for surgical repair of the humerus fracture on 3/12/15. Upon return from the hospital, the 5 day MDS dated 3/22/15, the 14 day MDS dated 3/29/15, and the 30 day MDS dated 4/12/15, all indicated there had been no ambulation in the bedroom or hallway during the observation periods. Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as cognitively intact with dependence on staff for activities of daily living (ADL). The nursing assistant care sheet dated 7/1/15, indicated: "non ambulatory for in room and	F 311		

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F 311	Continued From page 30 hallway." When interviewed on 7/2/15, at 1:12 p.m., the physical therapy assistant (PTA) thought it was possible the nursing referral sheet had not been completed and passed on to the nurse. The PTA expressed training two nursing assistants to ambulate R43 using the left arm and the handrail in the hallway. When interviewed on 7/2/15, at 1:20 p.m., RN-A expressed not knowing R43 could walk and acknowledged the process had been "dropped" because nursing had not received the rehab referral from the therapy department. Additional information was submitted by the executive director of the facility, after survey, July 7, 2015: "R43's ability to ambulate had been inconsistent since her admission due to instability secondary to right humeral fracture, then due to surgical repair of the humeral fracture with restrictions of the RUE [right upper extremity] and then with a significant laceration to her LLE [left lower extremity] with edema." "Point of Care Documentation shows that R43 has never ambulated in the hallway since her admission. She has been inconsistent but does ambulate in her room with extensive assistance of one staff. She maintains her ability to participate consistently in her bed mobility. Upon discharge from physical therapy 4/10/2015 R43 did not achieve her goal of ambulation 50 feet with staff assistance but was ambulating a distance of 15 feet with contact guard assistance."	F 311		

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F 311	Continued From page 31 "Resident R43 was referred to therapies on 7/7/2015 for gait training and to initiate a gait program. On 7/7/2015 Resident (R43) current level of function is noted that she ambulates 15 feet on even surfaces with minimal assist using left handrail and right upper extremity supported on therapies arm. Resident's current level of function demonstrates that she continues to improve and did not have a loss of ability. A walking program has been put in place. R43 is currently receiving pain medication to promote mobility".	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 offer timely repositioning to 1 of 1 resident (R43) who was assessed to be at risk for developing pressure ulcers and developed a pressure ulcer after admission to the facility. Findings include:	F 314	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions	8/11/15

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F 314	Continued From page 32 R43 was admitted 2/6/15, from an assisted living facility, due to a non-repaired fracture of the right humerus (upper arm,) with instructions to wear a splint to the right arm with limited mobility. Document review of R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent with activities of daily living (ADL's). The MDS indentified R43 was at risk for the development of pressure ulcers. There were no unstageable skin issues and no pressure ulcers identified. The first documentation that identified R43 had an unstageable pressure ulcer was 3/1/15, at 8:35 a.m. and read, "[R43] was found this morning by the attention of the NA/R (nursing assistant/registered) with three open areas to [R43's] right gluteal fold. Area #1 (Superior) measures 1.5 cm (centimeter) x 1.5 cm. Area #2 (Medial) measures 3 cm x 1 cm. Area #3 (Posterior) measures 1 cm x 2 cm. Allevyn thin applied to Superior area, protective ointment applied to medial and posterior areas. Area #1 unstageable, dark area present over area. Area #2 and #3 beefy red. No C/O's (complaints of) pain with dressing the area. Will update MD and get official treatment to areas." The next wound documentation in the progress notes was made on 3/4/15, at 7:40 p.m., and read; "[R43] right buttock presents with three open areas. The most superior is unstagable, covered with thick, firm cap of slough. It is surrounded by beefy redness. Peri wound is blancheable. Medial buttock with are of [sic] shearing. Allevyn Gentle Border dressing (small) placed atop superior wound. 4 Layers of skin prep applied to medial and inferior areas to	F 314	of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43 a comprehensive assessment has been performed. Care plan has been reviewed and revised related to repositioning. Wound treatment and monitoring was initiated with the discovery of the pressure area. Area continues to show improvement. b) Residents have a comprehensive assessment completed upon admission, quarterly and with a significant change. c) Nursing staff will receive re-edcuation related to care plan interventions, repositioning, and skin observations. d) DNS/Designess will audit 2 resident records per week related to pressure areas and repositioning for 4 weeks then 1 resident record for 4 weeks. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

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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 314	Continued From page 33 protect skin. [R43] denies discomfort with any of the areas palpated or treatment performed. Will ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 3/1/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biofilm formation and decrease edge senscence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift." The form titled, Treatment Record, for June 2015 and July 2015, read, "Reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift. Start date 4/2/15." Although the treatment record directed staff to reposition R43 every 30 minutes when up in the wheelchair, review of the nursing assistant care	F 314		

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	245320	A. BUILDING _____ B. WING _____	07/02/2015

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F 314	Continued From page 34 sheet dated, 6/30/15, read, "reposition every 2 hours. During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. Review of wound measurements from 6/30/15	F 314		

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F 314	Continued From page 35 and documentation from the Skin/Wound note which read; "1.6 x 1 x 0.2 cm (centmeter) 100% granulation tissue. No tunneling noted with gentle probing of wound bed. Cleansed. Patted Dry. 2 x 2 gauze pad cut in half and moistened with acetic acid. Placed in wound bed. Covered with ABD pad and secured with hypafix tape." The largest measurements for the right superior area were recorded in the progress notes 3/15/15, as 4.3 x 2.5 cm. (centimeter) Depth is =/> [sic] 2.6 cm. Documentation in the progress notes indicated the right medial and right inferior buttock wounds healed 3/18/15. The superior decubitus was measured on 6/30/15, as 1.6 length x 1.0 width x .20 depth in centimeters. The facility transitional care physician documented a visit to R43 on the form titled, Healtheast Medical Care for Seniors dated 3/2/15, however, there was no mention of any buttock wound issues. Furthermore the physician documented visits to R43 on 3/6/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15 and did not address any buttock wound issues. On 3/27/15, the physician wrote, "Breakdown of skin involving buttock region. Nursing staff request referral to wound clinic which is made. Additionally, load-off cushion to the chair and air mattress are to be obtained." During an interview with the director of nursing (DON), registered nurse (RN)-A and RN-C on 7/2/15, at 10:00 a.m., there was no data or information available indicating specific skin inspections associated with bathday prior to the unstageable wound discovery 3/1/15, because the facility documented in the computerized progress notes a statement which read, "bruises"	F 314		

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F 314	Continued From page 36 associated with the admission right arm fracture, and if there was no skin issue, there would be no other documentation. The undated facility policy, titled, Comprehensive Skin and Positioning Evaluation UDA (User Defined Assessment) was not used for R43 because the facility did not use the form until there were wounds, according to the DON. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		8/11/15

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F 329	Continued From page 37 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview 2 of 10 residents (R1, R69) medications reviewed did not have monitoring of specific target behaviors related to the use of the anti-anxiety medication clonazepam for R1 and did not assure physician orders were followed for R69. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed the resident was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1- (Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused cares, could be delusional, and can't stop talking.	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#1, resident's care plan has been reviewed and revised to reflect appropriate target behaviors related to the use of psychoactive medications. b) With respect to R#69, resident's blood sugar and blood pressure parameters were reviewed with MD. c) All residents receiving psychoactive medications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behaviors are identified. Care plans updated as needed.	

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F 329	Continued From page 38 R69's medical record lacked documentation ensuring adequate monitoring of medications. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for accuchecks, call MD (doctor of medicine) or NP (nurse practitioner) for blood glucose less than 75 or greater that 400. A review of R69's medication administration record (MAR) for June, 2015 indicated fifteen readings greater than 400 had been recorded. However, a review of progress notes for the month of June, 2015, lacked indication of MD or NP notification of blood glucose readings greater than 400. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for "Metoprolol Tartrate [medication for high blood pressure] 50 mg 8a and 8p hold for SBP [systolic blood pressure] less than 110." Review of R69's MAR for June, 2015 indicated on 6/26/15, R69's blood pressure was 109/76, and R69's medication was not held. There was no documentation the BP had been retaken and review of progress notes for June, 2015, lacked documentation regarding the low blood pressure or of any follow-up. When interviewed on 7/2/15, at 10:27 a.m., LPN-C verified the June, 2015, blood glucose results and indicated the expectation was for the nurse to call the MD when the blood glucose was greater than 400. LPN-C also verified the low blood pressure reading on 6/26/15, and indicated the expectation was for the nurse to hold the medication per parameters, and follow up on the low blood pressure.	F 329	d) Licensed staff will receive re-education regarding the use of psychoactive medication. e) Licensed staff will receive re-education on notification of MD. f) DNS/Designee will audit 2 resident records for target behaviors per week for 4 weeks then 1 resident record for 4 weeks. g) Results of these audits will be documented in the facilty's quality assurance meeting and reviewed by IDT for 3 months. h) DNS/Designee is responsible for completion.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		8/11/15

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F 428	Continued From page 39 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities regarding the lack of specific target behaviors related to the use of an anti-anxiety medication for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam (anti-anxiety medication) 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed R1 was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1-(Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#1, a medication review was completed by consulting pharmacist. b) All residents receiving psychoactive medications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behaviors are identified. Care plans updated as needed.	

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F 428	Continued From page 40 manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused care, could be delusional, and could not stop talking. The Record of Medication Regimen Review form dated 5/19 and 6/18/15, revealed the consulting pharmacist had reviewed R1's drug regimen. However, there were no notes or recommendations found in the record regarding the lack of specific target behavior of agitation for this resident. During a telephone interview on 7/2/15, at 2:25 p.m. the facility's consulting pharmacist was asked if she looked for specific target behaviors with the use of psychoactive medications when reviewing resident records. The consulting pharmacist replied that she did look for the specific target behaviors and made recommendations to use specific target behaviors. The surveyor mentioned there was a Consultant Pharmacist Communication to Nursing for this resident on 2/21/15, which included the recommendation to use "patient specific Target Behaviors" for the use of several other psychoactive medications that R1 was taking at that time. The consulting pharmacist explained she had spoken with the staff at the facility about this requirement and the nurse consultants for the facility stated were working on improving the documentation of appropriate target behaviors at this facility.	F 428	c) Nursing staff will receive re-education regarding the use of psychoactive medications. d) DNS/Designee will audit 2 resident records for target behaviors per week for 4 weeks then 1 resident record for 4 weeks. e) Results of these audits will be documented in the facilty's quality assurance meeting and reviewed by IDT for 3 months. f) DNS/Designee is responsible for completion.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		8/11/15

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F 431	Continued From page 41 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure four expired medications were removed from storage for 2 of 4 medication carts reviewed, potentially affecting 3 residents (R8, R22, R40).	F 431	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	

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F 431	Continued From page 42 Findings include: Review of the medication cart for the 600 hallway, on 6/29/15, at 12:35 p.m. the following were discovered: an open bottle of Levemir insulin for R8, with an opened on date of 5/12/15, (48 days prior); an open bottle of guaifenesin (cough medicine), 200 milligram (mg) tablets for R22, with an unreadable direction label, and an expiration date of 3/15. Registered nurse (RN)-B verified the medications were expired and should not be used, and the direction label on the bottle of guaifenesin was unreadable. Review of the medication cart for the 500 hallway, on 6/29/15, at 12:53 p.m., the following were discovered: an open bottle of Lantus insulin for R40, with an opened on date of 5/22/15. (38 days prior.) Licensed Practical Nurse (LPN) - E verified the date and indicated the insulin was expired and should not be used. Review of R8's record indicated a physician order for Levemir solution (Insulin Detemir) Inject 28 unit subcutaneously every evening shift for diabetes. Review of R22's record indicated a physician order for guaifenesin tablet 400 mg tablet oral cough when necessary (prn.) Review of R40's record indicated a physician order for Lantus Solution (Insulin Glargine) Inject 8 unit subcutaneously one time a day related to	F 431	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#8, R#22 and R#40, an audit has been performed to ensure that there no expired medications. b) All facility medicaiton carts will be audited to ensure all expired medicaitons have been removed and discontinued. c) Licensed staff will receive re-edcuation on the facility's medication expiration procedure. d) DNS/Designee will audit 1 medication cart per week for 8 weeks for expired medications. e) Results of these audits will be documented in the faciltiy's quality assurance meeting and reviwed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

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F 431	Continued From page 43 diabetes. The Medication Expiration Procedure dated March 2015, indicated insulin vials had an expiration date of 30 days after opening. The procedure also indicated medications would be discontinued at the date of expiration the medication.	F 431		

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 17, 2015

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

Subject: Woodlyn Heights IDR
Provider # 245320
Project # S5320025

Dear Ms. Donahue:

This is in response to your e-mail received on August 28, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F310 where corresponding state licensing order were issued pursuant to the survey completed on July 2, 2015.

The information presented with your letter, as well as in a face to face meeting with facility staff and MDH staff on September 24, 2015, the CMS and State 2567s dated July 2, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

State Tag ID Prefix 0915 – 4658.0525 Subp. 6A: **Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:**

A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:

(1) bathe, dress, and groom;
(2) transfer and ambulate;
(3) use the toilet;
(4) eat; and
(5) use speech, language, or other functional communication systems; and

Refer to summary outlined in the MDH letter dated 11/17/15 addressing the IDR for federal deficiencies. The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

Please note it is your responsibility to share the information contained in this letter and the results of

this review with the President of your facility's Governing Body.

Sincerely,

Christine Campbell, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-302-6151
Fax: 218-723-2359

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Susanne Reuss, Metro Team A District Office Unit Supervisor

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

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	00829	A. BUILDING: _____ B. WING _____	07/02/2015

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2 000	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. A complaint investigation was conducted to investigate complaint #H5320042. The complaint was not substantiated. 11/16/15 Revised MDH licensing orders as a result of an Informal Dispute Resolution.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		8/11/15

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2 570	Continued From page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to review and revise the care plan for 1 of 1 residents (R43) for ambulation and positioning and failed to revise the care plan for 1 of 1 resident (R69) for refusing weights. Findings include: R43's care plan was not updated to reflect a change for restorative nursing ambulation. R43's care plan dated, 2/18/15, directed staff for mobility "Limited physical mobility r/t (related to) right humeral arm fracture, advanced age, fall history and history of vertigo. Ambulation: Requires 2 staff assistance for mobility" R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R43 was discharged from physical therapy 4/10/15, with a notation on a form titled, Therapist Progress and Discharge Summary, to "ambulate 15 feet with L hall railing on even surfaces with care giver assistance. The long term goal read; ambulate x 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility)." Furthermore, the discharge summary read,	2 570	No POC required.	

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2 570	Continued From page 3 "Training provided to some of the nursing staff." R43's plan of care also directed staff; "[R43] has potential for impairment to skin integrity and pressure ulcer development with actual pressure ulcer at this time r/t (related to) advanced age, fragile skin, incontinence, functional decline, oxygen dependency, edema, and requiring assistance with bed mobility, transfers, hygiene, and ambulation." The Intervention read, "Encourage reposition/position changes during Customer Service Rounds." There were no other directions related to positioning in the wheel chair on the plan of care, however, the treatment sheet directed staff to "Reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift. Start date 4/2/15." During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes	2 570		

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2 570	Continued From page 4 and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour. R69's plan of care was not updated to include R69's refusal of care.	2 570		

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2 570	Continued From page 5 Review of R69's medical record indicated a physician order for "daily am (morning) weights. Record in point click. Notify MD for wgt (weight) gain 3 lbs/24 hrs (3 pounds in 24 hours) 5 lbs/week or wgt exceeding 10 lbs from admission weight (414.4 lbs)." Review of the medication administration record (MAR) indicated R 69 refused to be weighed every day in June. Review of R69's May 2015 MAR indicated the resident refused to be weighed all but two days. Review of R69's physician order record indicated a physician order for the following "CPAP [continuous positive airway pressure (used to keep airways open, used by people who have breathing problems, such as sleep apnea)] on HS [hour of sleep] off AM: Heated humidifier, full facemask (not nasal mask) head gear, filters and tubing. Pressure 8 cm of H2O [water]. Length of need: Indefinite. Must wear nightly" Review of R69's June MAR indicated R69 refused the CPAP every day in June. When interviewed on 7/2/15, at 10:27 a.m. licensed practical nurse (LPN)-C stated R69 refused to get out of bed daily, refused daily weights, and refused to wear the CPAP at night. LPN-C verified R69's refusal of care was not on the plan of care, and should have been. Suggested Method of Correction: The DON or desigee could work with the interdisciplinary team, MDS coordinator and nurse managers to review the assessments for accuracy, create comprehensive care plans, review and revise the procuedure for care plan updating, and then could educate staff. The DON or designee could	2 570		

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2 570	Continued From page 6 also perform audits of resident records to determine if the care plans were based on comprehensive assessment, updated in a timely fashion and then accessible for staff. Time Period for Correction: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to thoroughly document a nursing assessment after 1 of 1 resident (R55) complained of not feeling well and expired unexpectedly the following day. Findings include: Review of Progress Notes revealed that R55 was admitted to the facility 4/14/15, with admitting diagnoses that included chronic airway	2 830	No POC required.	8/11/15

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2 830	Continued From page 7 obstruction, diabetes, heart failure, hypertension, bipolar disorder, and sleep apnea. A late entry Progress Note, dated 4/26/15, read "Shortly before 1000 this nurse found the resident unresponsive in his room without a pulse and not breathing. Prior to this time we took his vitals which were within normal limits. Vitals were taken due to him not feeling well over the previous night..." Review of the record lacked documentation of recent vital signs, lacked nursing documentation of the resident's complaints when he was not feeling well, and lacked documetation of a nursing assessment. There was no nursing documentation in Progress Notes after 4/21/15, no temperature, pulse, or respiration documentation by nursing after 4/18/15, no blood pressure documentation after 4/24/15 and only one oxygen saturation level that was documented on 4/16/15. An acute visit note from a nurse practitioner, dated 4/24/15, indicated the resident was seen for "coarse breath sounds." R55 complained of not feeling well the night of 4/25/15 and expired unexpectedly on 4/26/15. When interviewed on 7/1/15, at 8:32 a.m. the director of nursing (DON) stated the nurse who cared for this resident no longer worked at the facility. At 9:00 a.m. the DON stated that no further documentation could be located regarding the events that occurred prior to R55's unexpected death. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding providing nursing care and supervision for residents according to the resident's individual needs and assessment. The DON or designee could monitor the care	2 830		

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2 830	Continued From page 8 provided to residents and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Thirty (21) days.	2 830		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain a resident's ability to ambulate for 1 of 1 resident (R43) reviewed for ambulation. Findings include: R43 had been admitted from an assisted living facility on 2/6/15,following a fall and fracture of the right humerus (upper arm). According to interagency transfer documentation at the time of admission, R43 had been ambulating 300 feet at the assisted living, according to the therapy goals. A fourteen day minimum data set (MDS)	2 885		8/11/15

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2 885	Continued From page 9 assessment dated 2/20/15, R43 had not walked in the corridor during the seven day assessment period, and had walked in the bedroom only once. A thirty day MDS dated 3/6/15, indicated R43 had not walked in the hallway, but had walked in the bedroom twice during the 7 day assessment period. A review of the physical therapy documentation titled, Physical Therapy (PT) Plan of Care, dated 2/6/15, included; "Goal Ambulate 75 feet with narrow base quad cane on even surfaces with CGA (care giver assistance). Current level of functioning Ambulates 35 feet with narrow base quad cane on even surfaces with MIN (minimum) assist secondary to occasional LOB (loss of balance). Goal date 3/31/15." According to the PT progress notes, R43 had been independently ambulating 300 feet in the assisted living setting prior to the right humerus fracture secondary to a fall. R43 was discharged from PT on 4/10/15, and the PT Discharge Summary included; "Training provided to some of the nursing staff for gait program." The current level of function was identified as; "Ambulates 15 feet with L (left) hall railing on even surfaces with CGA, Some of the nursing staff trained in walking with patient for FMP (full mobility potential) ." The physical therapy "Goal" included; "ambulate 300 feet with WW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SN (skilled nursing facility) setting." During observations from 4:45 p.m.- 6:00 p.m. on 6/29/15, R43 was not offered assistance or	2 885		

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2 885	Continued From page 10 encouragement to stand or walk. At 5:15 p.m., R43 was seated at the dining room table wearing gripper socks, with no foot pedals on the wheel chair. During an observation 7/1/15 from 7:00 a.m. until 7:30 a.m., R43 was seated in a wheel chair by a table near the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m., R43 was wheeled back to her bedroom. At 8:40 a.m. R43 was observed during a transfer. R43 was only able to tolerate standing for 30 seconds before stating, "that's enough!" R43 was then assisted to transfer to her bed with the assistance of one staff, nursing assistant (NA)-A. During the observation, NA-A verified at 8:40 a.m. that R43 had been transferred into the wheelchair at 6:30 a.m. without an encouragement/assistance to ambulate. NA-A stated R43 was not physically able to take any steps. NA-A stated she herself worked full time on the unit, but had not walked or attempted to walk R43 since admission/re-admission. Family member (F)-A was present during the transfer 7/1/15, at 8:40 a.m., and acknowledged that staff did not ambulate R43. F-A stated, "They stopped walking her." F-A further stated R43 had been independent in the assisted living prior to the fractured right arm, and said she was afraid R43 would lose her ability to walk. During this conversation, R43 expressed a desire to be walked in hopes of returning to the assisted living. During an interview on 7/2/14, at 11:00 a.m., with NA-B, another full time staff, she stated she did not realize R43 was supposed to ambulate. During an interview with licensed practical nurse	2 885		

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2 885	Continued From page 11 (LPN)-A on 7/2/15 at 11:30 a.m., she verified she was aware R43 could take steps, but did not know there was an ambulation program for R43. At that time, registered nurse (RN)-C was interviewed. RN-C stated she was the person who completed the MDS assessments. She stated R43 had been admitted as extensive assist of 2 staff for walking in the room, and verified R43 had walked in the hallway five of the seven observation days during an assessment review period (ARD) of 2/17/15. Additional record review revealed R43 had been discharged to the hospital for surgical repair of the humerus fracture on 3/12/15. Upon return from the hospital, the 5 day MDS dated 3/22/15, the 14 day MDS dated 3/29/15, and the 30 day MDS dated 4/12/15, all indicated there had been no ambulation in the bedroom or hallway during the observation periods. Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as cognitively intact with dependence on staff for activities of daily living (ADL). The nursing assistant care sheet dated 7/1/15, indicated: "non ambulatory for in room and hallway." When interviewed on 7/2/15, at 1:12 p.m., the physical therapy assistant (PTA) thought it was possible the nursing referral sheet had not been completed and passed on to the nurse. The PTA expressed training two nursing assistants to ambulate R43 using the left arm and the handrail in the hallway. When interviewed on 7/2/15, at 1:20 p.m., RN-A expressed not knowing R43 could walk and	2 885		

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2 885	Continued From page 12 acknowledged the process had been "dropped" because nursing had not received the rehab referral from the therapy department. Additional information was submitted by the executive director of the facility, after survey, July 7, 2015: "R43's ability to ambulate had been inconsistent since her admission due to instability secondary to right humeral fracture, then due to surgical repair of the humeral fracture with restrictions of the RUE [right upper extremity] and then with a significant laceration to her LLE [left lower extremity] with edema." "Point of Care Documentation shows that R43 has never ambulated in the hallway since her admission. She has been inconsistent but does ambulate in her room with extensive assistance of one staff. She maintains her ability to participate consistently in her bed mobility. Upon discharge from physical therapy 4/10/2015 R43 did not achieve her goal of ambulation 50 feet with staff assistance but was ambulating a distance of 15 feet with contact guard assistance." "Resident R43 was referred to therapies on 7/7/2015 for gait training and to initiate a gait program. On 7/7/2015 Resident (R43) current level of function is noted that she ambulates 15 feet on even surfaces with minimal assist using left handrail and right upper extremity supported on therapies arm. Resident's current level of function demonstrates that she continues to improve and did not have a loss of ability. A walking program has been put in place. R43 is currently receiving pain medication to promote mobility".	2 885		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 885	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure activities of daily living is provided. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	2 885		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 900	No POC required.	8/11/15

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2 900	Continued From page 14 review the facility failed to offer timely repositioning to 1 of 1 resident (R43) who was assessed to be at risk for developing pressure ulcers and developed a pressure ulcer after admission to the facility. Findings include: R43 was admitted 2/6/15, from an assisted living facility, due to a non-repaired fracture of the right humerus (upper arm,) with instructions to wear a splint to the right arm with limited mobility. Document review of R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent with activities of daily living (ADL's). The MDS indentified R43 was at risk for the development of pressure ulcers. There were no unstageable skin issues and no pressure ulcers identified. The first documentation that identified R43 had an unstageable pressure ulcer was 3/1/15, at 8:35 a.m. and read, "[R43] was found this morning by the attention of the NA/R (nursing assistant/registered) with three open areas to [R43's] right gluteal fold. Area #1 (Superior) measures 1.5 cm (centimeter) x 1.5 cm. Area #2 (Medial) measures 3 cm x 1 cm. Area #3 (Posterior) measures 1 cm x 2 cm. Allevyn thin applied to Superior area, protective ointment applied to medial and posterior areas. Area #1 unstageable, dark area present over area. Area #2 and #3 beefy red. No C/O's (complaints of) pain with dressing the area. Will update MD and get official treatment to areas." The next wound documentation in the progress notes was made on 3/4/15, at 7:40 p.m., and read; "[R43] right buttock presents with three	2 900		

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2 900	Continued From page 15 open areas. The most superior is unstagable, covered with thick, firm cap of slough. It is surrounded by beefy redness. Peri wound is blancheable. Medial buttock with are of [sic] shearing. Allevyn Gentle Border dressing (small) placed atop superior wound. 4 Layers of skin prep applied to medial and inferior areas to protect skin. [R43] denies discomfort with any of the areas palpated or treatment performed. Will ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 3/1/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biofilm formation and decrease edge senscence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift." The form titled, Treatment Record, for June 2015	2 900		

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2 900	Continued From page 16 and July 2015, read, "Reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift. Start date 4/2/15." Although the treatment record directed staff to reposition R43 every 30 minutes when up in the wheelchair, review of the nursing assistant care sheet dated, 6/30/15, read, "reposition every 2 hours. During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not	2 900		

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2 900	Continued From page 17 incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. Review of wound measurements from 6/30/15 and documentation from the Skin/Wound note which read; "1.6 x 1 x 0.2 cm (centmeter) 100% granulation tissue. No tunneling noted with gentle probing of wound bed. Cleansed. Patted Dry. 2 x 2 gauze pad cut in half and moistened with acetic acid. Placed in wound bed. Covered with ABD pad and secured with hypafix tape." The largest measurements for the right superior area were recorded in the progress notes 3/15/15, as 4.3 x 2.5 cm. (centimeter) Depth is =/> [sic] 2.6 cm. Documentation in the progress notes indicated the right medial and right inferior buttock wounds healed 3/18/15. The superior decubitus was measured on 6/30/15, as 1.6 length x 1.0 width x .20 depth in centimeters. The facility transitional care physician documented a visit to R43 on the form titled, Healtheast Medical Care for Seniors dated 3/2/15, however, there was no mention of any buttock wound issues. Furthermore the physician documented visits to R43 on 3/6/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15 and did not address any buttock wound issues. On 3/27/15, the physician wrote, "Breakdown of skin involving buttock region. Nursing staff request referral to wound clinic which is made. Additionally, load-off cushion to the chair and air mattress are to be obtained." During an interview with the director of nursing (DON), registered nurse (RN)-A and RN-C on 7/2/15, at 10:00 a.m., there was no data or information available indicating specific skin	2 900		

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2 900	Continued From page 18 inspections associated with bathday prior to the unstageable wound discovery 3/1/15, because the facility documented in the computerized progress notes a statement which read, "bruises" associated with the admission right arm fracture, and if there was no skin issue, there would be no other documentation. The undated facility policy, titled, Comprehensive Skin and Positioning Evaluation UDA (User Defined Assessment) was not used for R43 because the facility did not use the form until there were wounds, according to the DON. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding providing nursing care and supervision for residents according to the resident's individual needs and assessment. The DON or designee could monitor the care provided to residents and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Thirty (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and	21426		8/11/15

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21426	Continued From page 19 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide tuberculosis screening for 4 of 5 employees (E-A, E-B, E-C, E-E) and 2 of 5 residents (R47, F115) reviewed for tuberculosis screening. Findings include: Employee record review revealed employee (E)-A, hired 5/18/15, did not have a completed symptom screening and had only one step of tuberculin skin testing documented on 5/16/14. E-B, hired 4/7/15, had only one step of tuberculin skin testing documented on 4/4/15.	21426	No POC required.	

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21426	Continued From page 20 E-C, hired 2/19/15, had a chest x-ray report, dated 1/19/04, that read, "Indication: +PPD. Impression: Negative chest." There was no documentation of a corresponding physical examination with the chest x-ray. E-E, hired 4/7/15, had a chest x-ray report, dated 11/08/11, that read, "INDICATION: Positive Mantoux...FINDINGS: ...Lungs are clear of active disease... " There was no documentation of a corresponding physical examination with the chest x-ray. Review of R47's record showed the resident was admitted on 6/15/13 and the only documentation in the record for testing for presence of tuberculosis infection was from a previous admission in 2011. R115's record showed she was admitted 4/4/15 and the only documentation in the record for testing for presence of tuberculosis infection was a one-step tuberculin skin test dated 1/4/15. The facility's tuberculosis policy, dated 4/2/15, read, "Baseline TB screening is required at the time of hire for all health care workers in Minnesota. Baseline TB screening includes: (1) assessing for current symptoms of active TB disease, (2) assessing TB history, and (3) testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test...Baseline TB screening of patients is required at time of admission for health care settings licensed as boarding care homes and nursing homes. Baseline TB screening includes: (1) two-step TST or single TB blood test, (2) TB symptom screen, and (3) assessment of the patient's risk factors for TB.	21426		

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21426	Continued From page 21 When interviewed on 7/2/15, at 9:30 a.m. the surveyor requested the missing documentation from the director of nursing and she stated that she would look for it. During a phone interview on 7/7/15, at 2:10 p.m. the director of nursing stated that she could not locate any more documentation at this point, but would keep looking. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise Infection Control/tuberculosis program and ensure that resident and staff tuberculosis prevention are monitored and analyzed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services	21530		8/11/15

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21530	Continued From page 22 and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities regarding the lack of specific target behaviors related to the use of an anti-anxiety medication for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam (anti-anxiety medication) 1 milligram (mg) by mouth at bedtime for paranoid	21530	No POC required.	

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21530	Continued From page 23 schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed R1 was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1-(Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused care, could be delusional, and could not stop talking. The Record of Medication Regimen Review form dated 5/19 and 6/18/15, revealed the consulting pharmacist had reviewed R1's drug regimen. However, there were no notes or recommendations found in the record regarding the lack of specific target behavior of agitation for this resident. During a telephone interview on 7/2/15, at 2:25 p.m. the facility's consulting pharmacist was asked if she looked for specific target behaviors with the use of psychoactive medications when reviewing resident records. The consulting pharmacist replied that she did look for the specific target behaviors and made recommendations to use specific target behaviors. The surveyor mentioned there was a Consultant Pharmacist Communication to Nursing for this resident on 2/21/15, which included the recommendation to use "patient specific Target Behaviors" for the use of several other psychoactive medications that R1 was taking at that time. The consulting pharmacist	21530		

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21530	Continued From page 24 explained she had spoken with the staff at the facility about this requirement and the nurse consultants for the facility stated were working on improving the documentation of appropriate target behaviors at this facility. SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing could in-service and monitor for compliance with maintaining a functional and safe pharmaceuticals services for the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21535		8/11/15

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21535	Continued From page 25 available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on record review and interview 2 of 10 residents (R1, R69) medications reviewed did not have monitoring of specific target behaviors related to the use of the anti-anxiety medication clonazepam for R1 and did not assure physician orders were followed for R69. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed the resident was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1- (Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused cares, could be delusional, and can't stop talking. R69's medical record lacked documentation ensuring adequate monitoring of medications. Review of R69's Medication Review Report dated	21535	No POC required.	

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21535	Continued From page 26 7/1/15, indicated a physician order for accuchecks, call MD (doctor of medicine) or NP (nurse practitioner) for blood glucose less than 75 or greater that 400. A review of R69's medication administration record (MAR) for June, 2015 indicated fifteen readings greater than 400 had been recorded. However, a review of progress notes for the month of June, 2015, lacked indication of MD or NP notification of blood glucose readings greater than 400. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for "Metoprolol Tartrate [medication for high blood pressure] 50 mg 8a and 8p hold for SBP [systolic blood pressure] less than 110." Review of R69's MAR for June, 2015 indicated on 6/26/15, R69's blood pressure was 109/76, and R69's medication was not held. There was no documentation the BP had been retaken and review of progress notes for June, 2015, lacked documentation regarding the low blood pressure or of any follow-up. When interviewed on 7/2/15, at 10:27 a.m., LPN-C verified the June, 2015, blood glucose results and indicated the expectation was for the nurse to call the MD when the blood glucose was greater than 400. LPN-C also verified the low blood pressure reading on 6/26/15, and indicated the expectation was for the nurse to hold the medication per parameters, and follow up on the low blood pressure. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order.	21535		

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21535	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as	21545		8/11/15

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21545	Continued From page 28 prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure four expired medications were removed from storage for 2 of 4 medication carts reviewed, potentially affecting 3 residents (R8, R22, R40). Findings include: Review of the medication cart for the 600 hallway, on 6/29/15, at 12:35 p.m. the following were discovered: an open bottle of Levemir insulin for R8, with an opened on date of 5/12/15, (48 days prior); an open bottle of guaifenesin (cough medicine), 200 milligram (mg) tablets for R22, with an unreadable direction label, and an expiration date of 3/15. Registered nurse (RN)-B verified the medications were expired and should not be used, and the direction label on the bottle of guaifenesin was unreadable. Review of the medication cart for the 500 hallway, on 6/29/15, at 12:53 p.m., the following were discovered: an open bottle of Lantus insulin for R40, with an opened on date of 5/22/15. (38 days prior.)	21545	No POC required.	

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21545	Continued From page 29 Licensed Practical Nurse (LPN) - E verified the date and indicated the insulin was expired and should not be used. Review of R8's record indicated a physician order for Levemir solution (Insulin Detemir) Inject 28 unit subcutaneously every evening shift for diabetes. Review of R22's record indicated a physician order for guaifenesin tablet 400 mg tablet oral cough when necessary (prn.) Review of R40's record indicated a physician order for Lantus Solution (Insulin Glargine) Inject 8 unit subcutaneously one time a day related to diabetes. The Medication Expiration Procedure dated March 2015, indicated insulin vials had an expiration date of 30 days after opening. The procedure also indicated medications would be discontinued at the date of expiration the medication. Suggested Method of Correction: The director of nursing (DON) or designee could conduct training for all staff responsible for administering medication to residents to ensure staff are following facility policies and procedures and ensure medication expirations are not occurring.The DON or designee could monitor to ensure medication expiration dates are not occurring. Time Period for Correction: Fourteen (14) days.	21545		

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21695	Continued From page 30	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the bathroom was free of odors and kept in a cleanable condition for 2 of 2 residents (R65, R51) reviewed for room odors. Findings include: When interviewed on 6/30/15, at 10:46 a.m. R65 stated an odor was noted in the bathroom, and "it really smells ripe in there." At this time a stale urine odor was noted in the bathroom. On 7/2/15, at 11:05 a.m. the bathroom of R65 and R51 were noted to have a strong odor of stale urine. The director of environmental services [DES] reported the odor from the bathroom was a chronic issue. The DES stated housekeeping had informed him they clean the bathroom, and then the gentlemen in the room miss the toilet bowl when urinating. The DES reported the issue may be with the grout on the floor or the toilet. At this time the backsplash against the sink was coming away from the wall and the DES confirmed this finding. The 7 Step Daily Washroom Cleaning procedure,	21695	No POC required.	8/11/15

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21695	Continued From page 31 dated 1/1/2000, directed staff "1. Check Supplies.", "2. Empty Trash", 3. Dust Mop Floor", 4. Clean and Sanitize Sink and Tub", "5. Clean and Sanitize the Commode.", "6. Spot Clean Walls and/or Partitions" and "7. Damp Mop Floor." SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop a system to ensure the environment was clean, comfortable, without odors and checked on a routine basis. The Administrator or designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The director of facility operations or designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty-one (21) days.	21695		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on family and resident council concerns regarding call light wait times which had the potential to impact 6 of 6 residents reviewed; R77, R9, R11, R52, R115 and R64.	21870	No POC required.	8/11/15

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21870	Continued From page 32 Findings include: Review of Resident Council Meeting Agenda and Minutes, dated 4/21/15, revealed in new business "Long call light time" with an action plan "new shipment of radios was received, we are in the process of marking them and getting them distributed to staff" This should help with the call light wait times." On 5/19/15 the Resident Council Meeting Agenda and Minutes noted in Old Business "Long call light time" with the action "New shipment of radios was received, will be addressed in nurse and nurse's aide meetings, and education of staff on spot audits." Resolution and date included "Ongoing monitoring of the situation and education of staff. Continuing date for resolution. Addressed in meetings on 5/20 and 5/21." The minutes did not include comments on resident satisfaction with call light wait time progress. The Resident Council Meeting Agenda and Minutes for 6/23/15, did not include follow up on call light wait times, despite being noted as requiring continued action and monitoring on the 5/19/15 minutes. Family Townhall Minutes, dated 5/21/15, revealed "2. Nurses/aide relationship-seems to be no teamwork. They aren't responding to residents if they aren't on their wing or if it's not their job. 3. Timely call light times, long call light time during meal times. 4. Aides hide on the weekend, is there an incentive for them to not do so?" The Action Plan noted "Customer Service rounds are there to help, will continue to re-educate staff on teamwork. Upcoming staff training scheduled for June. 3. Continuing to work on this issue, again, Customer Service rounds are being done and that helps with this issue, and we have a new radio system in place to communicate more	21870		

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21870	Continued From page 33 effectively. 4. There is a Manager on Duty on the weekends. Encouraged to speak with them, as well as fill out a feedback form. Talk with the nurses if this occurs in the PM [evening/afternoon]. New radio that were recently purchased should help as well." There were no more recent meetings for Family Townhall. The facility failed to follow up on concerns related to call light wait times for R77. A review of R77 annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use and personal hygiene and was totally dependent on staff for transfers. On 7/1/15 at 3:15 p.m. R77 reported he waited several minutes for assistance on a recent night to help move his legs back on the bed and to get a window closed when his room was cold. R77 reported he had spoke with the administrator, current and former director of nursing about call light wait times. On 7/2/15 at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed, R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. A review of call light log for 6/21/15 to 6/27/15 revealed R77 waited over a half hour for assistance on the following instances: morning of 6/21, morning of 6/22, twice on the morning of 6/23, morning of 6/26 and morning of 6/27. The facility failed to follow up on call light wait time concerns for R9. R9's most recent quarterly Minimum Data Set	21870		

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21870	Continued From page 34 [MDS], dated 5/5/15 further confirmed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15 quarterly MDS further revealed she was moderately cognitively impaired and was frequently incontinent of urine and bowel. On 6/29/15 at 5:21 p.m. a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable time. F-B reported she had observed R9 wait over an hour for help. F-B reported "some aides don't care and don't come to button calls." F-B added R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie system used to alert them of call lights. F-B reported extended call light times occurred on various shifts and had occurred on a daily basis. F-B reported she visited R9 daily at various times. A review of call light times, for June 11th through June 24th 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11, morning and afternoon on 6/13, afternoon and evening on 6/15, afternoon of 6/16, morning of 6/17, morning of 6/18, afternoon of 6/18 and morning of 6/24. The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring.	21870		

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21870	Continued From page 35 On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light on, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of 6/21/15 and the afternoon of 6/27/15. Review of R115's most recent admission MDS, dated 4/21/15, revealed R115 had severe cognitive impairment and required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. On 6/30/15, at 10:37 a.m. a family member of R115, (F)-C, reported she had put her call light on when R115 was in the bathroom and sometimes	21870		

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21870	Continued From page 36 waited 30 minutes for staff to help. Review of R115's call light record for 6/21 to 6/27/15 revealed the following wait times were over 30 minutes: the evenings of 6/21 and 6/22/15; and the afternoons of 6/22, 6/23 and 6/26/15. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkies. The facility had investigated call light wait times from the previous week after surveyor brought the concern to the facility's attention, but could not reach a conclusion. Any additional follow up information from the resident council concerns was requested and the administrator reported there was nothing further. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. During an interview on 6/30/15, at 8:39 a.m. R64 who was cognitively intact, expressed frustration with attending resident council meetings because, while residents share how call lights are not being answered in a timely fashion the facility failed to adequately address the residents concern. R64 stated staff ignore the walkie talkies when they go off for a call light. R64 expressed personally seeing staff sleeping on the couches or playing cards at the table at 5:00 a.m. and turning off the call light beepers. R64 stated they had informed	21870		

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21870	Continued From page 37 facility staff of these issues and knew call light issues had been discussed at several resident council meetings. R64 stated, "Going to the resident council meetings is a meet, eat, and retreat meeting, because things discussed do not change." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review or revise policies, provide education for staff regarding resident grievance process. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. Time Period for Correction:Twenty-one (21) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section	21880		8/11/15

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21880	Continued From page 38 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to actively resolve personal grievances expressed for 2 of 2 residents (R9, R77) regarding call light wait times. Findings include: The facility failed to resolve a grievance regarding call light wait times, expressed by R9's family. On 6/29/15, at 5:21 p.m., a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable period of time. F-B reported they had observed R9 wait over an hour	21880	No POC required.	

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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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21880	Continued From page 39 for help, and stated "some aides don't care and don't come to button calls." F-B added, R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie talk system used to alert them of call lights. F-B reported visiting R9 daily, at various times, and on various shifts and had observed extended call light times during visits. On 7/2/15, at 9:08 a.m., F-B reported she had expressed concerns about call light wait times at care conferences, had spoken with the administrator and other staff about call light concerns. F-B reported at one point, after waiting an hour and a half for R9 to get assistance she "went off on them and told them that was not acceptable." F-B added "they tell us to tell them when this happens, but nothing ever changes" and "they claim they have a system, but I said clearly it is not working." F-B reported these concerns were brought up about 2-3 months ago and a facility response was never received. A review of a Feedback Form dated 5/11/15, revealed F-B had expressed concerns about R9 waiting an unacceptable time for call light response. The facility noted they had educated the nursing assistants and were working on distributing more portable walkies to alert staff of call light alerts. However, there was no indication this measure had resolved the grievance, as there was no monitoring of the measure, as the facility was unable to provide documentation of monitoring. A review of call light times, for June 11 - 24, 2015 revealed R9's call light times exceeded thirty	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 40 minutes on the evening of 6/11/15; on the morning and afternoon of 6/13/15; on the afternoon and evening of 6/15/15; on the afternoon of 6/16 and 6/18/15; and on the mornings of 6/17, 6/18 and 6/24/15. R9's most recent quarterly Minimum Data Set [MDS] dated 5/5/15, revealed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15, quarterly MDS further revealed R9 was moderately cognitively impaired, and was frequently incontinent of urine and bowel. The facility failed to follow up on concerns related to call light wait times for R77. On 7/1/15, at 3:15 p.m. R77 reported waiting several minutes for assistance on a recent night for repositioning and to get a window closed, when his room was cold. R77 reported he had spoken with the administrator, current and former director of nursing about call light wait times. On 7/2/15, at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed. R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 41 A review of the call light log dated 6/21 to 6/27/15, revealed R77 waited over half an hour for assistance on the following dates: the mornings of 6/21,6/22, 6/26 and 6/27; and twice on the mornings of 6/22 and 6/23/15. A review of R77's annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, and was totally dependent on staff for transfers. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkie talkies. The facility had investigated call light wait times from the previous week after surveyor brought the concerns to their attention, but could not reach a conclusion. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. SUGGESTED METHOD OF CORRECTION: The director of Social Services or designee could make sure resident grievances are listened to, acted upon and that results are reported back to the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1RUJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/10//2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(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 :
Jacob Mabera, HFE NE II — 10/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/22/2015 (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
07/01/1986
(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.
03001
(L31)

30. REMARKS
Posted 10/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/07/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245320
October 22, 2015

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

Dear Ms. Donahue:

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

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

Effective October 1, 2015 the above facility is certified for or recommended for:

99 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 99 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 22, 2015

Ms. Nicole Donahue, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number S5320025

Dear Ms. Donahue:

On September 10, 2015, we informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 2, 2015, that included an investigation of complaint number H5320041, and lack of verification of substantial compliance with the health deficiencies at the time of our September 10, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 1, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a complaint investigation, completed on July 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2015, as of October 1, 2015.

As a result of the PCR findings, this Department is also recommending to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 2, 2015, is to be rescinded.

In our letter of September 10, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245320	A. Building B. Wing	9/10/2015

Name of Facility	Street Address, City, State, Zip Code
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/11/2015**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/11/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/11/2015**	ID Prefix **F0310** Reg. # **483.25(a)(1)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/11/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/11/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/11/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	10/15/2015	32613	09/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/2/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 15, 2015

Ms. Nicole Donahue, Administrator Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number S5320025

Dear Ms. Donahue:

On September 10, 2015, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 11, 2015. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 2, 2015, that included an investigation of complaint number H5320041, and lack of verification of substantial compliance with the health deficiencies at the time of our September 10, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 1, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a complaint investigation, completed on July 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2015, as of October 1, 2015.

As a result of the PCR findings, this Department has taken the following action:

- State Monitoring effective August 11, 2015 is rescinded effective October 2, 2015. (42 CFR 488.422)

This Department is also recommending to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 2, 2015, is to be rescinded.

In our letter of September 10, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00829	A. Building B. Wing	10/1/2015

Name of Facility	Street Address, City, State, Zip Code
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21850** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	**10/01/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/KJ	10/22/2015	35456	10/01/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/11/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00829	A. Building B. Wing	9/10/2015

Name of Facility	Street Address, City, State, Zip Code
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **08/11/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **08/11/2015**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **08/11/2015**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **08/11/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	Correction Completed **08/11/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **08/11/2015**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 ABC** LSC	Correction Completed **08/11/2015**	ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **08/11/2015**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **08/11/2015**
ID Prefix **21870** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **08/11/2015**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	Correction Completed **08/11/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	10/15/2015	32613	09/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/2/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1RUJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

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)

6. DATE OF SURVEY **07/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(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 :
Mary Beth Lacina, HFE NE II 07/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 08/07/2015 Co.
DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 2, 2015

Ms. Nicole Donahue, Administrator Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number S5320025

Dear Ms. Donahue:

On July 2, 2015, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 2, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5320042 that was found to be unsubstantiated.

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:

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

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

<u>Remedies</u> - 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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 August 11, 2015, 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 August 11, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and 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 October 2, 2015 (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 January 2, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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. A complaint investigation was conducted to investigate complaint #H5320042. The complaint was not substantiated.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to actively resolve personal grievances expressed for 2 of 2 residents (R9, R77) regarding call light wait times. Findings include: The facility failed to resolve a grievance regarding call light wait times, expressed by R9's family.	F 166	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions	8/11/15

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

Electronically Signed | 07/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	07/02/2015

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F 166	Continued From page 1 On 6/29/15, at 5:21 p.m., a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable period of time. F-B reported they had observed R9 wait over an hour for help, and stated "some aides don't care and don't come to button calls." F-B added, R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie talk system used to alert them of call lights. F-B reported visiting R9 daily, at various times, and on various shifts and had observed extended call light times during visits. On 7/2/15, at 9:08 a.m., F-B reported she had expressed concerns about call light wait times at care conferences, had spoken with the administrator and other staff about call light concerns. F-B reported at one point, after waiting an hour and a half for R9 to get assistance she "went off on them and told them that was not acceptable." F-B added "they tell us to tell them when this happens, but nothing ever changes" and "they claim they have a system, but I said clearly it is not working." F-B reported these concerns were brought up about 2-3 months ago and a facility response was never received. A review of a Feedback Form dated 5/11/15, revealed F-B had expressed concerns about R9 waiting an unacceptable time for call light response. The facility noted they had educated the nursing assistants and were working on distributing more portable walkies to alert staff of call light alerts. However, there was no indication this measure had resolved the grievance, as	F 166	of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#9 and R#77, patterns of call light response times were assessed to determine care times, medication schedule, and activity preferences for reducing the need to call and wait for assistance. b) All staff will receive re-edcuation on responding to call lights in a timely manner and turning off the call light when entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with concerns from resident/family council meetings. d) The facility's interdisciplinary team (IDT) will audit via resident interviews, observations and/or call logs. Any call light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by the IDT for 3 months. f) DNS/Designee is responsible for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 2	F 166		

there was no monitoring of the measure, as the facility was unable to provide documentation of monitoring.

A review of call light times, for June 11 - 24, 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11/15; on the morning and afternoon of 6/13/15; on the afternoon and evening of 6/15/15; on the afternoon of 6/16 and 6/18/15; and on the mornings of 6/17, 6/18 and 6/24/15.

R9's most recent quarterly Minimum Data Set [MDS] dated 5/5/15, revealed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15, quarterly MDS further revealed R9 was moderately cognitively impaired, and was frequently incontinent of urine and bowel.

The facility failed to follow up on concerns related to call light wait times for R77.

On 7/1/15, at 3:15 p.m. R77 reported waiting several minutes for assistance on a recent night for repositioning and to get a window closed, when his room was cold. R77 reported he had spoken with the administrator, current and former director of nursing about call light wait times. On 7/2/15, at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed. R77 reported call light concerns were a chronic issue with not enough done to resolve the issue.

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F 166	Continued From page 3 Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented. A review of the call light log dated 6/21 to 6/27/15, revealed R77 waited over half an hour for assistance on the following dates: the mornings of 6/21,6/22, 6/26 and 6/27; and twice on the mornings of 6/22 and 6/23/15. A review of R77's annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, and was totally dependent on staff for transfers. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkie talkies. The facility had investigated call light wait times from the previous week after surveyor brought the concerns to their attention, but could not reach a conclusion. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		8/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 4 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 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.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete an accurate and thorough investigation related to an injury of unknown origin, and failed to report accurate details of the injury to the designated State agency (SA) for 1 of 3 residents (R43), reviewed for allegations of abuse/neglect or mistreatment. Findings include: A facility incident report indicated that on 4/21/15 at 11:00 a.m. R43 had sustained an injury of unknown origin identified as: "skin tear transfer from w/c (wheel chair) to bed. Significant gash required ED (emergency department) transfer." Documentation indicated that although the facility had reported to the State agency, they had not clearly identified the severity of the resident's wound. The following had been reported to the State Agency on 4/21/15 (no time of day specified): "Nursing assistant reported finding a skin tear on the lower left leg of the resident. Resident is unable to identify how the injury occurred. Resident was sent into the ER (emergency room) for evaluation and treatment. Internal investigation pending." On 4/27/15 (no time of day specified), the facility had submitted to the State Agency their investigative findings: "Resident obtained a skin tear on the outer aspect of her left lower leg. [Nursing assistant] (NA)-C] and [NA-D] were assisting the resident with transfer to bed from resident wheelchair. Nursing assistants deny any complication with transfer from wheelchair to bed. Resident denies knowing how she obtained skin	F 225	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43, internal investigation revealed laceration likely caused by the mechanism of the foot rest on the wheelchair. b) Facility will complete and report accurate and thorough investigations in accordance with State law (including to the State survey and certification agencies)within 5 working days of the incident. If alleged violation is verified appropriate corrective action will be taken. c) Staff will receive re-education on completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incident to ensure an accurate and thorough investigation is completed. This information will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 225	Continued From page 6 tear. Resident had worked with therapy earlier in the day. Therapy staff denies any complications with therapy session. Resident remains confused and unable to give any insight as to how the skin tear was acquired. Resident was sent into the ER to be evaluated, and returned to the facility same day with sutures closing the skin tear. After internal investigation, it appears as though the resident may have caught her leg on the release mechanism on the leg of her wheelchair, as the skin tear and wheelchair leg release align with height of injury. Upon completion of internal investigation no abuse or neglect was substantiated." Although the facility had reported the injury of unknown origin as a skin tear to the State agency, review of the emergency room documentation dated 4/21/15, identified and described the injury of unknown origin as; "left lower leg lacerations. Pt (patient) has a 10-11 cm (centimeter) y shaped laceration to left lower lateral leg that is gaping and has fat globals [sic] evident. Unsure of what happen [sic] that caused laceration, no falls, possibility a piece on the wheelchair. The wound was closed using one layer suture closure: skin layer: 22 sutures placed, stitch type; simple interrupted, suture: 3-0 prolene. The laceration was Y- shaped, deep, under a lot of tension, and measured 19 cm total length. The laceration was difficult to repair since the skin was very thin and there was a large amount of tension. Every effort was made to approximate the wound edges." The discharge information from the ER identified the treated diagnosis as a 19 cm complex leg laceration. Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as	F 225	e) The ED/Designee is responsible for completion	

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	245320	A. BUILDING _____ B. WING _____	07/02/2015

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F 225	Continued From page 7	F 225		

cognitively intact with dependence on staff for assistance with activities of daily living (ADL's).

During an interview with family member (F)-A on 7/1/15, at 8:00 a.m., F-A discussed an incident that occurred to R43 and expressed concern that staff did not inform F-A of the outcome of the investigation as to how the incident occurred. F-A expressed seeing a large 7 inch plate size area of blood and fat on the floor before R43 was transported by paramedics to the emergency room. F-A stated, "It looked like a pile of afterbirth on the floor." Furthermore, F-A explained R43 complained when the two aides stood her up, 'my leg really itches, what is the matter with it?' The pants leg was then pulled up and revealed the huge "blow out" according to F-A. According to F-A, the emergency room physician had speculated that the calf may have been pinched in the wheel chair and when the pressure of the pinching was relieved, the skin just "blew apart".

When interviewed on 7/2/15 at 8:25 a.m., the administrator acknowledged having been verbally informed of the incident on 4/21/15, although stated he had not seen the incident report until the file had been discovered in the former director of nursing's (DON) office after she'd left their employment. The administrator stated that upon finding the report, it had been signed by the assistant director of nursing (ADON) and himself on 6/1/15. He verified there had been no further clarifying documentation or investigation conducted since and acknowledged that the former DON had not followed through with the investigation. There had been no statements from the resident who was cognitively intact, no witness statements, no environment review, and no education and/or training to prevent

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F 225	Continued From page 8 recurrence of the incident. The facility's current Policy and Procedure titled, Vulnerable Adult Abuse/Neglect Prevention, included under section #9; "Injuries of Unknown Source/Unexplained Injuries. An injury should be classified as an injury of unkown source" when both the following conditions are met: Federal: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and b.The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vuylnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. State: If a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained." The policy further included information for Submitting the Report, listed under Internal Reporting procedures; "1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following a review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, placed under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the protection of the resident 3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of	F 225		

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F 225	Continued From page 9 the reported allegation or incident". The policy directed staff to consider investigating and interviewing the following: Interviews of staff, Resident interviews, Environmental review, Resident health status, Behavior review, Medication review.	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 document review and interview, the facility failed to implement their policies for investigation related to an injury of unknown origin for 1 of 3 residents (R43), reviewed for allegations of abuse/neglect or mistreatment. Findings include: The facility's current Policy and Procedure titled, Vulnerable Adult Abuse/Neglect Prevention, included under section #9; "Injuries of Unknown Source/Unexplained Injuries. An injury should be classified as an injury of unkown source" when both the following conditions are met: Federal: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and b.The injury is suspiciouys because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally	F 226	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43, internal investigation revealed laceration likely caused by the mechanism of the foot rest on the wheelchair. b) Facility will complete and report accurate and thorough investigations in	8/11/15

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F 226	Continued From page 10 vuylnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. State: If a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained." The policy further included information for Submitting the Report, listed under Internal Reporting procedures; "1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following a review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing. 2. Upon report to a Supervisor of the suspected abuse, the employee in question will be interviewed, re-assigned duties, placed under the direct supervision of a licensed nurse, assigned to non-resident related tasks or suspended pending investigation. This is for the protection of the resident 3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident". The policy directed staff to consider investigating and interviewing the following: Interviews of staff, Resident interviews, Environmental review, Resident health status, Behavior review, Medication review. A facility incident report indicated that on 4/21/15 at 11:00 a.m. R43 had sustained an injury of unknown origin identified as: "skin tear transfer from w/c (wheel chair) to bed. Significant gash required ED (emergency department) transfer."	F 226	accordance with State law (including to the State survey and certification agencies)within 5 working days of the incident. If alleged violation is verified appropriate corrective action will be taken. c) Staff will receive re-education on completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incident to ensure an accurate and thorough investigation is completed. This information will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. e) The ED/Designee is responsible for completion	

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Documentation indicated that although the facility had reported to the State agency, they had not accurately described the severity of the resident's wound. The following had been reported to the State Agency on 4/21/15 (no time of day specified): "Nursing assistant reported finding a skin tear on the lower left leg of the resident. Resident is unable to identify how the injury occurred. Resident was sent into the ER (emergency room) for evaluation and treatment. Internal investigation pending."

On 4/27/15 (no time of day specified), the facility had submitted to the State Agency their investigative findings: "Resident obtained a skin tear on the outer aspect of her left lower leg. [Nursing assistant] (NA)-C] and [NA-D] were assisting the resident with transfer to bed from resident wheelchair. Nursing assistants deny any complication with transfer from wheelchair to bed. Resident denies knowing how she obtained skin tear. Resident had worked with therapy earlier in the day. Therapy staff denies any complications with therapy session. Resident remains confused and unable to give any insight as to how the skin tear was acquired. Resident was sent into the ER to be evaluated, and returned to the facility same day with sutures closing the skin tear. After internal investigation, it appears as though the resident may have caught her leg on the release mechanism on the leg of her wheelchair, as the skin tear and wheelchair leg release align with height of injury. Upon completion of internal investigation no abuse or neglect was substantiated."

Although the facility had reported the injury of unknown origin as a skin tear to the State agency, review of the emergency room

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documentation dated 4/21/15, identified and described the injury of unknown origin as more significant; "left lower leg lacerations. Pt (patient) has a 10-11 cm (centimeter) y shaped laceration to left lower lateral leg that is gaping and has fat globals [sic] evident. Unsure of what happen [sic] that caused laceration, no falls, possibility a piece on the wheelchair. The wound was closed using one layer suture closure: skin layer: 22 sutures placed, stitch type; simple interrupted, suture: 3-0 prolene. The laceration was Y- shaped, deep, under a lot of tension, and measured 19 cm total length. The laceration was difficult to repair since the skin was very thin and there was a large amount of tension. Every effort was made to approximate the wound edges." The discharge information from the ER identified the treated diagnosis as a 19 cm complex leg laceration.

Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as cognitively intact with dependence on staff for assistance with activities of daily living (ADL's).

During an interview with family member (F)-A on 7/1/15, at 8:00 a.m., F-A discussed an incident that occurred to R43 and expressed concern that staff did not inform F-A of the outcome of the investigation as to how the incident occurred. F-A expressed seeing a large 7 inch plate size area of blood and fat on the floor before R43 was transported by paramedics to the emergency room. F-A stated, "It looked like a pile of afterbirth on the floor." Furthermore, F-A explained R43 complained when the two aides stood her up, 'my leg really itches, what is the matter with it?' The pants leg was then pulled up and revealed the huge "blow out" according to F-A. According to F-A, the emergency room physician had

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F 226	Continued From page 13 speculated that the calf may have been pinched in the wheel chair and when the pressure of the pinching was relieved, the skin just "blew apart". When interviewed on 7/2/15 at 8:25 a.m., the administrator acknowledged having been verbally informed of the incident on 4/21/15, although stated he had not seen the incident report until the file had been discovered in the former director of nursing's (DON) office after she'd left their employ. The administrator stated that upon finding the report, it had been signed by the assistant director of nursing (ADON) and himself on 6/1/15. He verified there had been no further clarifying documentation or investigation conducted since and acknowledged that the former DON had not followed through with the investigation. There had been no statements from the resident who was cognitively intact, no witness statements, no environmental review, and no education and/or training to prevent recurrence of the incident.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on family and resident council concerns regarding call light wait times	F 244	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	8/11/15

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F 244	Continued From page 14 which had the potential to impact 6 of 6 residents reviewed; R77, R9, R11, R52, R115 and R64. Findings include: Review of Resident Council Meeting Agenda and Minutes, dated 4/21/15, revealed in new business "Long call light time" with an action plan "new shipment of radios was received, we are in the process of marking them and getting them distributed to staff" This should help with the call light wait times." On 5/19/15 the Resident Council Meeting Agenda and Minutes noted in Old Business "Long call light time" with the action "New shipment of radios was received, will be addressed in nurse and nurse's aide meetings, and education of staff on spot audits." Resolution and date included "Ongoing monitoring of the situation and education of staff. Continuing date for resolution. Addressed in meetings on 5/20 and 5/21." The minutes did not include comments on resident satisfaction with call light wait time progress. The Resident Council Meeting Agenda and Minutes for 6/23/15, did not include follow up on call light wait times, despite being noted as requiring continued action and monitoring on the 5/19/15 minutes. Family Townhall Minutes, dated 5/21/15, revealed "2. Nurses/aide relationship-seems to be no teamwork. They aren't responding to residents if they aren't on their wing or if it's not their job. 3. Timely call light times, long call light time during meal times. 4. Aides hide on the weekend, is there an incentive for them to not do so?" The Action Plan noted "Customer Service rounds are there to help, will continue to re-educate staff on teamwork. Upcoming staff training scheduled for June. 3. Continuing to work on this issue, again,	F 244	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#77, R#9, R#11, R#52, R#115 & R#64 patterns of call light response times were assessed to determine care times, medication schedule, and activity preferences for reducing the need to call and wait for assistance. b) All staff will receive re-edcuation on responding to call lights in a timely manner and turning off the call light when entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with concerns from resident/family council meetings. d) The facility's interdisciplinary team (IDT) will audit via resident interviews, observations and/or call logs. Any call light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by the IDT for 3 months.	

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F 244	Continued From page 15 Customer Service rounds are being done and that helps with this issue, and we have a new radio system in place to communicate more effectively. 4. There is a Manager on Duty on the weekends. Encouraged to speak with them, as well as fill out a feedback form. Talk with the nurses if this occurs in the PM [evening/afternoon]. New radio that were recently purchased should help as well." There were no more recent meetings for Family Townhall. The facility failed to follow up on concerns related to call light wait times for R77. A review of R77 annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use and personal hygiene and was totally dependent on staff for transfers. On 7/1/15 at 3:15 p.m. R77 reported he waited several minutes for assistance on a recent night to help move his legs back on the bed and to get a window closed when his room was cold. R77 reported he had spoke with the administrator, current and former director of nursing about call light wait times. On 7/2/15 at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed, R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. A review of call light log for 6/21/15 to 6/27/15 revealed R77 waited over a half hour for assistance on the following instances: morning of 6/21, morning of 6/22, twice on the morning of 6/23, morning of 6/26 and morning of 6/27.	F 244	f) DNS/Designee is responsible for completion.	

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The facility failed to follow up on call light wait time concerns for R9.

R9's most recent quarterly Minimum Data Set [MDS], dated 5/5/15 further confirmed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15 quarterly MDS further revealed she was moderately cognitively impaired and was frequently incontinent of urine and bowel.

On 6/29/15 at 5:21 p.m. a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable time. F-B reported she had observed R9 wait over an hour for help. F-B reported "some aides don't care and don't come to button calls." F-B added R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie system used to alert them of call lights. F-B reported extended call light times occurred on various shifts and had occurred on a daily basis. F-B reported she visited R9 daily at various times.

A review of call light times, for June 11th through June 24th 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11, morning and afternoon on 6/13, afternoon and evening on 6/15, afternoon of 6/16, morning of 6/17, morning of 6/18, afternoon of 6/18 and morning of 6/24.

The facility failed to follow up on call light wait

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F 244	Continued From page 17 times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light on, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of 6/21/15 and the afternoon of 6/27/15. Review of R115's most recent admission MDS, dated 4/21/15, revealed R115 had severe cognitive impairment and required extensive	F 244		

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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 244	Continued From page 18 assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. On 6/30/15, at 10:37 a.m. a family member of R115, (F)-C, reported she had put her call light on when R115 was in the bathroom and sometimes waited 30 minutes for staff to help. Review of R115's call light record for 6/21 to 6/27/15 revealed the following wait times were over 30 minutes: the evenings of 6/21 and 6/22/15; and the afternoons of 6/22, 6/23 and 6/26/15. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkies. The facility had investigated call light wait times from the previous week after surveyor brought the concern to the facility's attention, but could not reach a conclusion. Any additional follow up information from the resident council concerns was requested and the administrator reported there was nothing further. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. During an interview on 6/30/15, at 8:39 a.m. R64 who was cognitively intact, expressed frustration with attending resident council meetings because, while residents share how call lights are not being	F 244		

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	245320	A. BUILDING _____ B. WING _____	07/02/2015

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F 244	Continued From page 19 answered in a timely fashion the facility failed to adequately address the residents concern. R64 stated staff ignore the walkie talkies when they go off for a call light. R64 expressed personally seeing staff sleeping on the couches or playing cards at the table at 5:00 a.m. and turning off the call light beepers. R64 stated they had informed facility staff of these issues and knew call light issues had been discussed at several resident council meetings. R64 stated, "Going to the resident council meetings is a meet, eat, and retreat meeting, because things discussed do not change."	F 244		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the bathroom was free of odors and kept in a cleanable condition for 2 of 2 residents (R65, R51) reviewed for room odors. Findings include: When interviewed on 6/30/15, at 10:46 a.m. R65 stated an odor was noted in the bathroom, and "it really smells ripe in there." At this time a stale urine odor was noted in the bathroom. On 7/2/15, at 11:05 a.m. the bathroom of R65 and R51 were noted to have a strong odor of stale	F 253	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#51 and R#65, the bathroom has been thoroughly cleaned	8/11/15

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F 253	Continued From page 20 urine. The director of environmental services [DES] reported the odor from the bathroom was a chronic issue. The DES stated housekeeping had informed him they clean the bathroom, and then the gentlemen in the room miss the toilet bowl when urinating. The DES reported the issue may be with the grout on the floor or the toilet. At this time the backsplash against the sink was coming away from the wall and the DES confirmed this finding. The 7 Step Daily Washroom Cleaning procedure, dated 1/1/2000, directed staff "1. Check Supplies.", "2. Empty Trash", 3. Dust Mop Floor", 4. Clean and Sanitize Sink and Tub", "5. Clean and Sanitize the Commode.", "6. Spot Clean Walls and/or Partitions" and "7. Damp Mop Floor."	F 253	and back splash was repaired. b) Cleaning procedure has been reviewed and revised. c) Housekeeping staff will receive re-education on the cleaning procedures. d) Healthcare Services Manager/Designee will audit 3 resident rooms per week for 8 weeks to ensure cleanliness. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. f) ED/Designee is responsible for completion.	
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	F 280		8/11/15

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F 280	Continued From page 21 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to review and revise the care plan for 1 of 1 residents (R43) for ambulation and positioning and failed to revise the care plan for 1 of 1 resident (R69) for refusing weights. Findings include: R43's care plan was not updated to reflect a change for restorative nursing ambulation. R43's care plan dated, 2/18/15, directed staff for mobility "Limited physical mobility r/t (related to) right humeral arm fracture, advanced age, fall history and history of vertigo. Ambulation: Requires 2 staff assistance for mobility" R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R43 was discharged from physical therapy 4/10/15, with a notation on a form titled, Therapist Progress and Discharge Summary, to "ambulate 15 feet with L hall railing on even surfaces with care giver assistance. The long term goal read; ambulate x 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43, a comprehensive assessment was completed. Care plan was updated to reflect current ambulation and repositioning care needs. b) With respect to R#69, care plan has been reviewed and revised to reflect refusal of cares. c) Licensed staff will receive re-education on reviewing and revision of the Care Plan. d) The DNS/Designee will audit 2 resident care plans per week for four weeks then 1 resident care plan per week for four weeks for ambulation, repositioning needs	

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F 280	Continued From page 22 facility) or SNF (skilled nursing facility)." Furthermore, the discharge summary read, "Training provided to some of the nursing staff." R43's plan of care also directed staff; "[R43] has potential for impairment to skin integrity and pressure ulcer development with actual pressure ulcer at this time r/t (related to) advanced age, fragile skin, incontinence, functional decline, oxygen dependency, edema, and requiring assistance with bed mobility, transfers, hygiene, and ambulation." The Intervention read, "Encourage reposition/position changes during Customer Service Rounds." There were no other directions related to positioning in the wheel chair on the plan of care, however, the treatment sheet directed staff to "Reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift. Start date 4/2/15." During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks,	F 280	and refusal of care. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

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F 280	Continued From page 23 during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour.	F 280		

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F 280	Continued From page 24 R69 plan of care was not updated to include R69's refusal of care. Review of R69's medical record indicated a physician order for "daily am (morning) weights. Record in point click. Notify MD for wgt (weight) gain 3 lbs/24 hrs (3 pounds in 24 hours) 5 lbs/week or wgt exceeding 10 lbs from admission weight (414.4 lbs)." Review of the medication administration record (MAR) indicated R 69 refused to be weighed every day in June. Review of R69's May 2015 MAR indicated the resident refused to be weighed all but two days. Review of R69's physician order record indicated a physician order for the following "CPAP [continuous positive airway pressure (used to keep airways open, used by people who have breathing problems, such as sleep apnea)] on HS [hour of sleep] off AM: Heated humidifier, full facemask (not nasal mask) head gear, filters and tubing. Pressure 8 cm of H2O [water]. Length of need: Indefinite. Must wear nightly" Review of R69's June MAR indicated R69 refused the CPAP every day in June. When interviewed on 7/2/15, at 10:27 a.m. licensed practical nurse (LPN)-C stated R69 refused to get out of bed daily, refused daily weights, and refused to wear the CPAP at night. LPN-C verified R69's refusal of care was not on the plan of care, and should have been.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		8/11/15

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F 309	Continued From page 25 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care, including a thorough nursing assessment, was provided for 1 of 1 resident (R55) who complained of not feeling well, and who expired unexpectedly the following day. Findings include: Review of Progress Notes revealed that R55 had been admitted to the facility 4/14/15, with admitting diagnoses that included: chronic airway obstruction, diabetes, heart failure, hypertension, bipolar disorder, and sleep apnea. A late entry Progress Note dated 4/26/15, included; "Shortly before 1000 this nurse found the resident unresponsive in his room without a pulse and not breathing. Prior to this time we took his vitals which were within normal limits. Vitals were taken due to him not feeling well over the previous night..." Review of the record lacked documentation of nursing assessment having been conducted including; recent vital signs, documentation of the resident's specific complaints when he was not feeling well, or any other documentation of a nursing assessment. There had been no nursing documentation in Progress Notes after 4/21/15. There was no documentation of temperature,	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#55, the nurse responsbile for failing to document a change of condition is no longer employed at the facility. b) Licensed staff will receive re-edcuation on documenting a resident's change in condition. c) DNS/Designee will audit 2 resident records for change in condition per week for 4 weeks then 1 resident record per week for 4 weeks. d) Results of these audits will be documented in the facilty's quality assurance meeting and reviewed by IDT for 3 months.	

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F 309	Continued From page 26 pulse, or respiration after 4/18/15, and no blood pressure documentation after 4/24/15. There was only one oxygen saturation level documented and that had occurred on 4/16/15. An acute visit note from a nurse practitioner, dated 4/24/15, indicated the resident had been seen for "coarse breath sounds." R55 complained of not feeling well the night of 4/25/15 and expired unexpectedly on 4/26/15. When interviewed on 7/1/15, at 8:32 a.m. the director of nursing (DON) stated the nurse who cared for this resident no longer worked at the facility. At 9:00 a.m. the DON stated that no further documentation of assessment could be located regarding the events that occurred prior to R55's unexpected death.	F 309	e) DNS/Designee is responsible for completion	
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain a resident's ability to ambulate for 1 of 1 resident	F 310	The facility does not agree with various facts and conclusions in the statement of deficiencies and licensing violations and is seeking an appeal at this time. The	8/11/15

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F 310	Continued From page 27 (R43) reviewed for ambulation. The failure of the facility to consistently implement an ambulation program resulted in harm for R43 who sustained decreased strength and inability to ambulate. Findings include: R43 had been admitted from an assisted living facility on 2/6/15,following a fall and fracture of the right humerus (upper arm). According to interagency transfer documentation at the time of admission, R43 had been ambulating 300 feet at the assisted living, according to the therapy goals. A fourteen day minimum data set (MDS) assessment dated 2/20/15, R43 had not walked in the corridor during the seven day assessment period, and had walked in the bedroom only once. A thirty day MDS dated 3/6/15, indicated R43 had not walked in the hallway, but had walked in the bedroom twice during the 7 day assessment period. A review of the physical therapy documentation titled, Physical Therapy (PT) Plan of Care, dated 2/6/15, included; "Goal Ambulate 75 feet with narrow base quad cane on even surfaces with CGA (care giver assistance). Current level of functioning Ambulates 35 feet with narrow base quad cane on even surfaces with MIN (minimum) assist secondary to occasional LOB (loss of balance). Goal date 3/31/15." According to the PT progress notes, R43 had been independently ambulating 300 feet in the assisted living setting prior to the right humurus fracture secondary to a fall.	F 310	preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nore an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) R#43 received Physical Therapy from date of admission until reaching a plateau. R#43 did not loose the ability to ambulate from the date of discharge from therapy to the time of survey. b) All residents' ambulation programs have been reviewed and care plans revised if needed. c) The facility's communication tool for ambulation programs has been reviewed and revised. d) Nursing and Therapy staff will recieve re-education regarding the use of the communication tool for ambulation programs. e) DNS/Designee will audit 2 resident records regarding ambulation per week for 4 weeks then 1 resident record per week for weeks. f) Results of these audits will be documented in the facilty's quality	

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F 310	Continued From page 28 R43 was discharged from PT on 4/10/15, and the PT Discharge Summary included; "Training provided to some of the nursing staff for gait program." The current level of function was identified as; "Ambulates 15 feet with L (left) hall railing on even surfaces with CGA, Some of the nursing staff trained in walking with patient for FMP (full mobility potential) ." The physical therapy "Goal" included; "ambulate 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility) setting." During observations from 4:45 p.m.- 6:00 p.m.on 6/29/15, R43 was not offered assistance or encouragement to stand or walk. At 5:15 p.m., R43 was seated at the dining room table wearing gripper socks, with no foot pedals on the wheel chair. During an observation 7/1/15 from 7:00 a.m. until 7:30 a.m., R43 was seated in a wheel chair by a table near the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m., R43 was wheeled back to her bedroom. At 8:40 a.m. R43 was observed during a transfer. R43 was only able to tolerate standing for 30 seconds before stating, "that's enough!" R43 was then assisted to transfer to her bed with the assistance of one staff, nursing assistant (NA)-A. During the observation, NA-A verified at 8:40 a.m. that R43 had been transferred into the wheelchair at 6:30 a.m. without an encouragement/assistance to ambulate. NA-A stated R43 was not physically able to take any steps. NA-A stated she herself worked full time on the unit, but had not walked or attempted to walk R43 since admission/re-admission.	F 310	assurance meeting and reviewed by IDT for 3 months. g) DNS/Designee is responsible for completion.	

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F 310	Continued From page 29	F 310		

Family member (F)-A was present during the transfer 7/1/15, at 8:40 a.m., and acknowledged that staff did not ambulate R43. F-A stated, "They stopped walking her."
F-A further stated R43 had been independent in the assisted living prior to the fractured right arm, and said she was afraid R43 would lose her ability to walk. During this conversation, R43 expressed a desire to be walked in hopes of returning to the assisted living.

During an interview on 7/2/14, at 11:00 a.m., with NA-B, another full time staff, she stated she did not realize R43 was suppposed to ambulate.

During an interview with licensed practical nurse (LPN)-A on 7/2/15 at 11:30 a.m., she verified she was aware R43 could take steps, but did not know there was an ambulation program for R43. At that time, registered nurse (RN)-C was interviewed. RN-C stated she was the person who completed the MDS assessments. She stated R43 had been admitted as extensive assist of 2 staff for walking in the room, and verified R43 had walked in the hallway five of the seven observation days during an assessment review period (ARD) of 2/17/15.

Additional record review revealed R43 had been discharged to the hospital for surgical repair of the humerus fracture on 3/12/15. Upon return from the hospital, the 5 day MDS dated 3/22/15, the 14 day MDS dated 3/29/15, and the 30 day MDS dated 4/12/15, all indicated there had been no ambulation in the bedroom or hallway during the observation periods.

Document review of R43's quarterly Minimum

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Data Set (MDS) dated 5/8/15, indentified R43 as cognitively intact with dependence on staff for activities of daily living (ADL).

The nursing assistant care sheet dated 7/1/15, indicated: "non ambulatory for in room and hallway."

When interviewed on 7/2/15, at 1:12 p.m., the physical therapy assistant (PTA) thought it was possible the nursing referral sheet had not been completed and passed on to the nurse. The PTA expressed training two nursing assistants to ambulate R43 using the left arm and the handrail in the hallway.

When interviewed on 7/2/15, at 1:20 p.m., RN-A expressed not knowing R43 could walk and acknowledged the process had been "dropped" because nursing had not received the rehab referral from the therapy department.

Additional information was submitted by the executive director of the facility, after survey, July 7, 2015:

"R43's ability to ambulate had been inconsistent since her admission due to instability secondary to right humeral fracture, then due to surgical repair of the humeral fracture with restrictions of the RUE [right upper extremity] and then with a significant laceration to her LLE [left lower extremity] with edema."

"Point of Care Documentation shows that R43 has never ambulated in the hallway since her admission. She has been inconsistent but does ambulate in her room with extensive assistance of one staff. She maintains her ability to

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F 310	Continued From page 31 participate consistently in her bed mobility. Upon discharge from physical therapy 4/10/2015 R43 did not achieve her goal of ambulation 50 feet with staff assistance but was ambulating a distance of 15 feet with contact guard assistance." "Resident R43 was referred to therapies on 7/7/2015 for gait training and to initiate a gait program. On 7/7/2015 Resident (R43) current level of function is noted that she ambulaters 15 feet on even surfaces with minimal assist using left handrail and right upper extremity supported on therapies arm. Resident's current level of function demonstrates that she continues to improve and did not have a loss of ability. A walking program has been put in place. R43 is currently receiving pain medication to promote mobility".	F 310		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 offer timely repositioning to 1 of 1 resident (R43) who was	F 314	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	8/11/15

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F 314	Continued From page 32 assessed to be at risk for developing pressure ulcers and developed a pressure ulcer after admission to the facility. Findings include: R43 was admitted 2/6/15, from an assisted living facility, due to a non-repaired fracture of the right humerus (upper arm,) with instructions to wear a splint to the right arm with limited mobility. Document review of R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent with activities of daily living (ADL's). The MDS indentified R43 was at risk for the development of pressure ulcers. There were no unstageable skin issues and no pressure ulcers identified. The first documentation that identified R43 had an unstageable pressure ulcer was 3/1/15, at 8:35 a.m. and read, "[R43] was found this morning by the attention of the NA/R (nursing assistant/registered) with three open areas to [R43's] right gluteal fold. Area #1 (Superior) measures 1.5 cm (centimeter) x 1.5 cm. Area #2 (Medial) measures 3 cm x 1 cm. Area #3 (Posterior) measures 1 cm x 2 cm. Allevyn thin applied to Superior area, protective ointment applied to medial and posterior areas. Area #1 unstageable, dark area present over area. Area #2 and #3 beefy red. No C/O's (complaints of) pain with dressing the area. Will update MD and get official treatment to areas." The next wound documentation in the progress notes was made on 3/4/15, at 7:40 p.m., and read; "[R43] right buttock presents with three open areas. The most superior is unstagable,	F 314	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#43 a comprehensive assessment has been performed. Care plan has been reviewed and revised related to repositioning. Wound treatment and monitoring was initiated with the discovery of the pressure area. Area continues to show improvement. b) Residents have a comprehensive assessment completed upon admission, quarterly and with a significant change. c) Nursing staff will receive re-edcuation related to care plan interventions, repositioning, and skin observations. d) DNS/Designess will audit 2 resident records per week related to pressure areas and repositioning for 4 weeks then 1 resident record for 4 weeks. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

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covered with thick, firm cap of slough. It is surrounded by beefy redness. Peri wound is blancheable. Medial buttock with are of [sic] shearing. Allevyn Gentle Border dressing (small) placed atop superior wound. 4 Layers of skin prep applied to medial and inferior areas to protect skin. [R43] denies discomfort with any of the areas palpated or treatment performed. Will ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders."

The form titled Medication Administration Record (MAR) dated 3/1/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift.

R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biofilm formation and decrease edge senscence."

Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift."

The form titled, Treatment Record, for June 2015

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and July 2015, read, "Reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift. Start date 4/2/15." Although the treatment record directed staff to reposition R43 every 30 minutes when up in the wheelchair, review of the nursing assistant care sheet dated, 6/30/15, read, "reposition every 2 hours.

During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m.

During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present

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to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock.

Review of wound measurements from 6/30/15 and documentation from the Skin/Wound note which read; "1.6 x 1 x 0.2 cm (centmeter) 100% granulation tissue. No tunneling noted with gentle probing of wound bed. Cleansed. Patted Dry. 2 x 2 gauze pad cut in half and moistened with acetic acid. Placed in wound bed. Covered with ABD pad and secured with hypafix tape."

The largest measurements for the right superior area were recorded in the progress notes 3/15/15, as 4.3 x 2.5 cm. (centimeter) Depth is =/> [sic] 2.6 cm. Documentation in the progress notes indicated the right medial and right inferior buttock wounds healed 3/18/15. The superior decubitus was measured on 6/30/15, as 1.6 length x 1.0 width x .20 depth in centimeters.

The facility transitional care physician documented a visit to R43 on the form titled, Healtheast Medical Care for Seniors dated 3/2/15, however, there was no mention of any buttock wound issues. Furthermore the physician documented visits to R43 on 3/6/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15 and did not address any buttock wound issues. On 3/27/15, the physician wrote, "Breakdown of skin involving buttock region. Nursing staff request referral to wound clinic which is made. Additionally, load-off cushion to the chair and air mattress are to be obtained."

During an interview with the director of nursing (DON), registered nurse (RN)-A and RN-C on

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F 314	Continued From page 36 7/2/15, at 10:00 a.m., there was no data or information available indicating specific skin inspections associated with bathday prior to the unstageable wound discovery 3/1/15, because the facility documented in the computerized progress notes a statement which read, "bruises" associated with the admission right arm fracture, and if there was no skin issue, there would be no other documentation. The undated facility policy, titled, Comprehensive Skin and Positioning Evaluation UDA (User Defined Assessment) was not used for R43 because the facility did not use the form until there were wounds, according to the DON. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		8/11/15

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F 329	Continued From page 37 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview 2 of 10 residents (R1, R69) medications reviewed did not have monitoring of specific target behaviors related to the use of the anti-anxiety medication clonazepam for R1 and did not assure physician orders were followed for R69. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed the resident was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1- (Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m.	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#1, resident's care plan has been reviewed and revised to reflect appropriate target behaviors related to the use of psychoactive medications. b) With respect to R#69, resident's blood sugar and blood pressure parameters were reviewed with MD.	

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F 329	Continued From page 38 licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused cares, could be delusional, and can't stop talking. R69's medical record lacked documentation ensuring adequate monitoring of medications. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for accuchecks, call MD (doctor of medicine) or NP (nurse practitioner) for blood glucose less than 75 or greater that 400. A review of R69's medication administration record (MAR) for June, 2015 indicated fifteen readings greater than 400 had been recorded. However, a review of progress notes for the month of June, 2015, lacked indication of MD or NP notification of blood glucose readings greater than 400. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for "Metoprolol Tartrate [medication for high blood pressure] 50 mg 8a and 8p hold for SBP [systolic blood pressure] less than 110." Review of R69's MAR for June, 2015 indicated on 6/26/15, R69's blood pressure was 109/76, and R69's medication was not held. There was no documentation the BP had been retaken and review of progress notes for June, 2015, lacked documentation regarding the low blood pressure or of any follow-up. When interviewed on 7/2/15, at 10:27 a.m., LPN-C verified the June, 2015, blood glucose results and indicated the expectation was for the nurse to call the MD when the blood glucose was greater than 400. LPN-C also verified the low blood pressure reading on 6/26/15, and indicated	F 329	c) All residents receiving psychoactive medications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behaviors are identified. Care plans updated as needed. d) Licensed staff will receive re-education regarding the use of psychoactive medication. e) Licensed staff will receive re-education on notification of MD. f) DNS/Designee will audit 2 resident records for target behaviors per week for 4 weeks then 1 resident record for 4 weeks. g) Results of these audits will be documented in the facilty's quality assurance meeting and reviewed by IDT for 3 months. h) DNS/Designee is responsible for completion.	

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F 329	Continued From page 39 the expectation was for the nurse to hold the medication per parameters, and follow up on the low blood pressure.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities regarding the lack of specific target behaviors related to the use of an anti-anxiety medication for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam (anti-anxiety medication) 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed R1 was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1-(Clonazepam) agitation..." There were no details	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#1, a medication review was completed by consulting pharmacist. b) All residents receiving psychoactive	8/11/15

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F 428	Continued From page 40 of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused care, could be delusional, and could not stop talking. The Record of Medication Regimen Review form dated 5/19 and 6/18/15, revealed the consulting pharmacist had reviewed R1's drug regimen. However, there were no notes or recommendations found in the record regarding the lack of specific target behavior of agitation for this resident. During a telephone interview on 7/2/15, at 2:25 p.m. the facility's consulting pharmacist was asked if she looked for specific target behaviors with the use of psychoactive medications when reviewing resident records. The consulting pharmacist replied that she did look for the specific target behaviors and made recommendations to use specific target behaviors. The surveyor mentioned there was a Consultant Pharmacist Communication to Nursing for this resident on 2/21/15, which included the recommendation to use "patient specific Target Behaviors" for the use of several other psychoactive medications that R1 was taking at that time. The consulting pharmacist explained she had spoken with the staff at the facility about this requirement and the nurse consultants for the facility stated were working on improving the documentation of appropriate target behaviors at this facility.	F 428	medications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behaviors are identified. Care plans updated as needed. c) Nursing staff will receive re-education regarding the use of psychoactive medications. d) DNS/Designee will audit 2 resident records for target behaviors per week for 4 weeks then 1 resident record for 4 weeks. e) Results of these audits will be documented in the facilty's quality assurance meeting and reviewed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	The preparation of the following plan of	8/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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 431	Continued From page 42 review the facility did not ensure four expired medications were removed from storage for 2 of 4 medication carts reviewed, potentially affecting 3 residents (R8, R22, R40). Findings include: Review of the medication cart for the 600 hallway, on 6/29/15, at 12:35 p.m. the following were discovered: an open bottle of Levemir insulin for R8, with an opened on date of 5/12/15, (48 days prior); an open bottle of guaifenesin (cough medicine), 200 milligram (mg) tablets for R22, with an unreadable direction label, and an expiration date of 3/15. Registered nurse (RN)-B verified the medications were expired and should not be used, and the direction label on the bottle of guaifenesin was unreadable. Review of the medication cart for the 500 hallway, on 6/29/15, at 12:53 p.m., the following were discovered: an open bottle of Lantus insulin for R40, with an opened on date of 5/22/15. (38 days prior.) Licensed Practical Nurse (LPN) - E verified the date and indicated the insulin was expired and should not be used. Review of R8's record indicated a physician order for Levemir solution (Insulin Detemir) Inject 28 unit subcutaneously every evening shift for diabetes. Review of R22's record indicated a physician order for guaifenesin tablet 400 mg tablet oral cough when necessary (prn.)	F 431	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#8, R#22 and R#40, an audit has been performed to ensure that there no expired medications. b) All facility medicaiton carts will be audited to ensure all expired medicaitons have been removed and discontinued. c) Licensed staff will receive re-edcuation on the facility's medication expiration procedure. d) DNS/Designee will audit 1 medication cart per week for 8 weeks for expired medications. e) Results of these audits will be documented in the faciltiy's quality assurance meeting and reviwed by IDT for 3 months. f) DNS/Designee is responsible for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	07/02/2015

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F 431	Continued From page 43 Review of R40's record indicated a physician order for Lantus Solution (Insulin Glargine) Inject 8 unit subcutaneously one time a day related to diabetes. The Medication Expiration Procedure dated March 2015, indicated insulin vials had an expiration date of 30 days after opening. The procedure also indicated medications would be discontinued at the date of expiration the medication.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/01/2015**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on July 01, 2015. At the time of this survey, Woodlyn Heights Healthcare Center was found 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. The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single story addition was added to the East and was determined to be of Type II(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building 1 was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19, and building 2 was surveyed in accordance with LSC Chapter 18. The builfing is fully fire sprinklered. and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 72 beds at the time of the survey.	K 000		

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

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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	245320	A. BUILDING **02 - 2014 ADDITION** B. WING _____	**07/01/2015**

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K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on July 01, 2015. At the time of this survey, Woodlyn Heights Healthcare Center was found 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.

The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single story addition was added to the East and was determined to be of Type II(111) construction.

This facility was surveyed as two separate buildings because of different dates of construction. Building 1 was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19, and building 2 was surveyed in accordance with LSC Chapter 18.

The builfing is fully fire sprinklered. and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 72 beds at the time of the survey.

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 16, 2015

Ms. Nicole Donahue, Administrator Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5320025

Dear Ms. Donahue:

The above facility was surveyed on June 29, 2015 through July 2, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5320042 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	07/02/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. A complaint investigation was conducted to investigate complaint #H5320042. The complaint was not substantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		8/11/15

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2 570	Continued From page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to review and revise the care plan for 1 of 1 residents (R43) for ambulation and positioning and failed to revise the care plan for 1 of 1 resident (R69) for refusing weights. Findings include: R43's care plan was not updated to reflect a change for restorative nursing ambulation. R43's care plan dated, 2/18/15, directed staff for mobility "Limited physical mobility r/t (related to) right humeral arm fracture, advanced age, fall history and history of vertigo. Ambulation: Requires 2 staff assistance for mobility" R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R43 was discharged from physical therapy 4/10/15, with a notation on a form titled, Therapist Progress and Discharge Summary, to "ambulate 15 feet with L hall railing on even surfaces with care giver assistance. The long term goal read; ambulate x 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility)." Furthermore, the discharge summary read,	2 570	No POC required.	

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2 570	Continued From page 3 "Training provided to some of the nursing staff." R43's plan of care also directed staff; "[R43] has potential for impairment to skin integrity and pressure ulcer development with actual pressure ulcer at this time r/t (related to) advanced age, fragile skin, incontinence, functional decline, oxygen dependency, edema, and requiring assistance with bed mobility, transfers, hygiene, and ambulation." The Intervention read, "Encourage reposition/position changes during Customer Service Rounds." There were no other directions related to positioning in the wheel chair on the plan of care, however, the treatment sheet directed staff to "Reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift. Start date 4/2/15." During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 4 and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour. R69's plan of care was not updated to include R69's refusal of care.	2 570		

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2 570	Continued From page 5 Review of R69's medical record indicated a physician order for "daily am (morning) weights. Record in point click. Notify MD for wgt (weight) gain 3 lbs/24 hrs (3 pounds in 24 hours) 5 lbs/week or wgt exceeding 10 lbs from admission weight (414.4 lbs)." Review of the medication administration record (MAR) indicated R 69 refused to be weighed every day in June. Review of R69's May 2015 MAR indicated the resident refused to be weighed all but two days. Review of R69's physician order record indicated a physician order for the following "CPAP [continuous positive airway pressure (used to keep airways open, used by people who have breathing problems, such as sleep apnea)] on HS [hour of sleep] off AM: Heated humidifier, full facemask (not nasal mask) head gear, filters and tubing. Pressure 8 cm of H2O [water]. Length of need: Indefinite. Must wear nightly" Review of R69's June MAR indicated R69 refused the CPAP every day in June. When interviewed on 7/2/15, at 10:27 a.m. licensed practical nurse (LPN)-C stated R69 refused to get out of bed daily, refused daily weights, and refused to wear the CPAP at night. LPN-C verified R69's refusal of care was not on the plan of care, and should have been. Suggested Method of Correction: The DON or desigee could work with the interdisciplinary team, MDS coordinator and nurse managers to review the assessments for accuracy, create comprehensive care plans, review and revise the procuedure for care plan updating, and then could educate staff. The DON or designee could	2 570		

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2 570	Continued From page 6 also perform audits of resident records to determine if the care plans were based on comprehensive assessment, updated in a timely fashion and then accessible for staff. Time Period for Correction: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to thoroughly document a nursing assessment after 1 of 1 resident (R55) complained of not feeling well and expired unexpectedly the following day. Findings include: Review of Progress Notes revealed that R55 was admitted to the facility 4/14/15, with admitting diagnoses that included chronic airway	2 830	No POC required.	8/11/15

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2 830	Continued From page 7 obstruction, diabetes, heart failure, hypertension, bipolar disorder, and sleep apnea. A late entry Progress Note, dated 4/26/15, read "Shortly before 1000 this nurse found the resident unresponsive in his room without a pulse and not breathing. Prior to this time we took his vitals which were within normal limits. Vitals were taken due to him not feeling well over the previous night..." Review of the record lacked documentation of recent vital signs, lacked nursing documentation of the resident's complaints when he was not feeling well, and lacked documetation of a nursing assessment. There was no nursing documentation in Progress Notes after 4/21/15, no temperature, pulse, or respiration documentation by nursing after 4/18/15, no blood pressure documentation after 4/24/15 and only one oxygen saturation level that was documented on 4/16/15. An acute visit note from a nurse practitioner, dated 4/24/15, indicated the resident was seen for "coarse breath sounds." R55 complained of not feeling well the night of 4/25/15 and expired unexpectedly on 4/26/15. When interviewed on 7/1/15, at 8:32 a.m. the director of nursing (DON) stated the nurse who cared for this resident no longer worked at the facility. At 9:00 a.m. the DON stated that no further documentation could be located regarding the events that occurred prior to R55's unexpected death. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding providing nursing care and supervision for residents according to the resident's individual needs and assessment. The DON or designee could monitor the care	2 830		

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2 830	Continued From page 8 provided to residents and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Thirty (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to offer timely repositioning to 1 of 1 resident (R43) who was assessed to be at risk for developing pressure ulcers and developed a pressure ulcer after admission to the facility. Findings include: R43 was admitted 2/6/15, from an assisted living	2 900	No POC required.	8/11/15

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2 900	Continued From page 9 facility, due to a non-repaired fracture of the right humerus (upper arm,) with instructions to wear a splint to the right arm with limited mobility. Document review of R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent with activities of daily living (ADL's). The MDS indentified R43 was at risk for the development of pressure ulcers. There were no unstageable skin issues and no pressure ulcers identified. The first documentation that identified R43 had an unstageable pressure ulcer was 3/1/15, at 8:35 a.m. and read, "[R43] was found this morning by the attention of the NA/R (nursing assistant/registered) with three open areas to [R43's] right gluteal fold. Area #1 (Superior) measures 1.5 cm (centimeter) x 1.5 cm. Area #2 (Medial) measures 3 cm x 1 cm. Area #3 (Posterior) measures 1 cm x 2 cm. Allevyn thin applied to Superior area, protective ointment applied to medial and posterior areas. Area #1 unstageable, dark area present over area. Area #2 and #3 beefy red. No C/O's (complaints of) pain with dressing the area. Will update MD and get official treatment to areas." The next wound documentation in the progress notes was made on 3/4/15, at 7:40 p.m., and read; "[R43] right buttock presents with three open areas. The most superior is unstagable, covered with thick, firm cap of slough. It is surrounded by beefy redness. Peri wound is blancheable. Medial buttock with are of [sic] shearing. Allevyn Gentle Border dressing (small) placed atop superior wound. 4 Layers of skin prep applied to medial and inferior areas to protect skin. [R43] denies discomfort with any of the areas palpated or treatment performed. Will	2 900		

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2 900	Continued From page 10 ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 3/1/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biofilm formation and decrease edge senscence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift." The form titled, Treatment Record, for June 2015 and July 2015, read, "Reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift. Start date 4/2/15." Although the treatment record directed staff to reposition R43 every 30 minutes when up in the wheelchair, review of the nursing assistant care sheet dated, 6/30/15, read, "reposition every 2 hours.	2 900		

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2 900	Continued From page 11 During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. Review of wound measurements from 6/30/15 and documentation from the Skin/Wound note which read; "1.6 x 1 x 0.2 cm (centmeter) 100% granulation tissue. No tunneling noted with gentle probing of wound bed. Cleansed. Patted Dry. 2 x	2 900		

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2 900	Continued From page 12 2 gauze pad cut in half and moistened with acetic acid. Placed in wound bed. Covered with ABD pad and secured with hypafix tape." The largest measurements for the right superior area were recorded in the progress notes 3/15/15, as 4.3 x 2.5 cm. (centimeter) Depth is =/> [sic] 2.6 cm. Documentation in the progress notes indicated the right medial and right inferior buttock wounds healed 3/18/15. The superior decubitus was measured on 6/30/15, as 1.6 length x 1.0 width x .20 depth in centimeters. The facility transitional care physician documented a visit to R43 on the form titled, Healtheast Medical Care for Seniors dated 3/2/15, however, there was no mention of any buttock wound issues. Furthermore the physician documented visits to R43 on 3/6/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15 and did not address any buttock wound issues. On 3/27/15, the physician wrote, "Breakdown of skin involving buttock region. Nursing staff request referral to wound clinic which is made. Additionally, load-off cushion to the chair and air mattress are to be obtained." During an interview with the director of nursing (DON), registered nurse (RN)-A and RN-C on 7/2/15, at 10:00 a.m., there was no data or information available indicating specific skin inspections associated with bathday prior to the unstageable wound discovery 3/1/15, because the facility documented in the computerized progress notes a statement which read, "bruises" associated with the admission right arm fracture, and if there was no skin issue, there would be no other documentation. The undated facility policy, titled, Comprehensive	2 900		

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2 900	Continued From page 13 Skin and Positioning Evaluation UDA (User Defined Assessment) was not used for R43 because the facility did not use the form until there were wounds, according to the DON. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding providing nursing care and supervision for residents according to the resident's individual needs and assessment. The DON or designee could monitor the care provided to residents and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Thirty (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom;	2 915		8/11/15

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2 915	Continued From page 14 (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain a resident's ability to ambulate for 1 of 1 resident (R43) reviewed for ambulation. The failure of the facility to consistently implement an ambulation program resulted in harm for R43 who sustained decreased strength and inability to ambulate. Findings include: R43 had been admitted from an assisted living facility on 2/6/15,following a fall and fracture of the right humerus (upper arm). According to interagency transfer documentation at the time of admission, R43 had been ambulating 300 feet at the assisted living, according to the therapy goals. A fourteen day minimum data set (MDS) assessment dated 2/20/15, R43 had not walked in the corridor during the seven day assessment period, and had walked in the bedroom only once. A thirty day MDS dated 3/6/15, indicated R43 had not walked in the hallway, but had walked in the bedroom twice during the 7 day assessment period.	2 915	No POC required.	

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2 915	Continued From page 15 A review of the physical therapy documentation titled, Physical Therapy (PT) Plan of Care, dated 2/6/15, included; "Goal Ambulate 75 feet with narrow base quad cane on even surfaces with CGA (care giver assistance). Current level of functioning Ambulates 35 feet with narrow base quad cane on even surfaces with MIN (minimum) assist secondary to occasional LOB (loss of balance). Goal date 3/31/15." According to the PT progress notes, R43 had been independently ambulating 300 feet in the assisted living setting prior to the right humurus fracture secondary to a fall. R43 was discharged from PT on 4/10/15, and the PT Discharge Summary included; "Training provided to some of the nursing staff for gait program." The current level of function was identified as; "Ambulates 15 feet with L (left) hall railing on even surfaces with CGA, Some of the nursing staff trained in walking with patient for FMP (full mobility potential) ." The physical therapy "Goal" included; "ambulate 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility) setting." During observations from 4:45 p.m.- 6:00 p.m.on 6/29/15, R43 was not offered assistance or encouragement to stand or walk. At 5:15 p.m., R43 was seated at the dining room table wearing gripper socks, with no foot pedals on the wheel chair. During an observation 7/1/15 from 7:00 a.m. until 7:30 a.m., R43 was seated in a wheel chair by a table near the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30	2 915		

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2 915	Continued From page 16	2 915		

a.m., R43 was wheeled back to her bedroom. At 8:40 a.m. R43 was observed during a transfer. R43 was only able to tolerate standing for 30 seconds before stating, "that's enough!" R43 was then assisted to transfer to her bed with the assistance of one staff, nursing assistant (NA)-A. During the observation, NA-A verified at 8:40 a.m. that R43 had been transferred into the wheelchair at 6:30 a.m. without an encouragement/assistance to ambulate. NA-A stated R43 was not physically able to take any steps. NA-A stated she herself worked full time on the unit, but had not walked or attempted to walk R43 since admission/re-admission.

Family member (F)-A was present during the transfer 7/1/15, at 8:40 a.m., and acknowledged that staff did not ambulate R43. F-A stated, "They stopped walking her."
F-A further stated R43 had been independent in the assisted living prior to the fractured right arm, and said she was afraid R43 would lose her ability to walk. During this conversation, R43 expressed a desire to be walked in hopes of returning to the assisted living.

During an interview on 7/2/14, at 11:00 a.m., with NA-B, another full time staff, she stated she did not realize R43 was suppposed to ambulate.

During an interview with licensed practical nurse (LPN)-A on 7/2/15 at 11:30 a.m., she verified she was aware R43 could take steps, but did not know there was an ambulation program for R43. At that time, registered nurse (RN)-C was interviewed. RN-C stated she was the person who completed the MDS assessments. She stated R43 had been admitted as extensive assist of 2 staff for walking in the room, and verified R43 had walked in the hallway five of the seven

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2 915	Continued From page 17 observation days during an assessment review period (ARD) of 2/17/15. Additional record review revealed R43 had been discharged to the hospital for surgical repair of the humerus fracture on 3/12/15. Upon return from the hospital, the 5 day MDS dated 3/22/15, the 14 day MDS dated 3/29/15, and the 30 day MDS dated 4/12/15, all indicated there had been no ambulation in the bedroom or hallway during the observation periods. Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, indentified R43 as cognitively intact with dependence on staff for activities of daily living (ADL). The nursing assistant care sheet dated 7/1/15, indicated: "non ambulatory for in room and hallway." When interviewed on 7/2/15, at 1:12 p.m., the physical therapy assistant (PTA) thought it was possible the nursing referral sheet had not been completed and passed on to the nurse. The PTA expressed training two nursing assistants to ambulate R43 using the left arm and the handrail in the hallway. When interviewed on 7/2/15, at 1:20 p.m., RN-A expressed not knowing R43 could walk and acknowledged the process had been "dropped" because nursing had not received the rehab referral from the therapy department. Additional information was submitted by the executive director of the facility, after survey, July 7, 2015: "R43's ability to ambulate had been inconsistent	2 915		

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2 915	Continued From page 18 since her admission due to instability secondary to right humeral fracture, then due to surgical repair of the humeral fracture with restrictions of the RUE [right upper extremity] and then with a significant laceration to her LLE [left lower extremity] with edema." "Point of Care Documentation shows that R43 has never ambulated in the hallway since her admission. She has been inconsistent but does ambulate in her room with extensive assistance of one staff. She maintains her ability to participate consistently in her bed mobility. Upon discharge from physical therapy 4/10/2015 R43 did not achieve her goal of ambulation 50 feet with staff assistance but was ambulating a distance of 15 feet with contact guard assistance." "Resident R43 was referred to therapies on 7/7/2015 for gait training and to initiate a gait program. On 7/7/2015 Resident (R43) current level of function is noted that she ambulaters 15 feet on even surfaces with minimal assist using left handrail and right upper extremity supported on therapies arm. Resident's current level of function demonstrates that she continues to improve and did not have a loss of ability. A walking program has been put in place. R43 is currently receiving pain medication to promote mobility". SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure activities of daily living is provided. The Director of Nursing Services or designee	2 915		

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2 915	Continued From page 19 could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	2 915		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide tuberculosis screening for 4 of 5 employees (E-A, E-B, E-C, E-E) and 2 of 5	21426	No POC required.	8/11/15

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21426	Continued From page 20 residents (R47, F115) reviewed for tuberculosis screening. Findings include: Employee record review revealed employee (E)-A, hired 5/18/15, did not have a completed symptom screening and had only one step of tuberculin skin testing documented on 5/16/14. E-B, hired 4/7/15, had only one step of tuberculin skin testing documented on 4/4/15. E-C, hired 2/19/15, had a chest x-ray report, dated 1/19/04, that read, "Indication: +PPD. Impression: Negative chest." There was no documentation of a corresponding physical examination with the chest x-ray. E-E, hired 4/7/15, had a chest x-ray report, dated 11/08/11, that read, "INDICATION: Positive Mantoux...FINDINGS: ...Lungs are clear of active disease... " There was no documentation of a corresponding physical examination with the chest x-ray. Review of R47's record showed the resident was admitted on 6/15/13 and the only documentation in the record for testing for presence of tuberculosis infection was from a previous admission in 2011. R115's record showed she was admitted 4/4/15 and the only documentation in the record for testing for presence of tuberculosis infection was a one-step tuberculin skin test dated 1/4/15. The facility's tuberculosis policy, dated 4/2/15, read, "Baseline TB screening is required at the time of hire for all health care workers in	21426		

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21426	Continued From page 21 Minnesota. Baseline TB screening includes: (1) assessing for current symptoms of active TB disease, (2) assessing TB history, and (3) testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test...Baseline TB screening of patients is required at time of admission for health care settings licensed as boarding care homes and nursing homes. Baseline TB screening includes: (1) two-step TST or single TB blood test, (2) TB symptom screen, and (3) assessment of the patient's risk factors for TB. When interviewed on 7/2/15, at 9:30 a.m. the surveyor requested the missing documentation from the director of nursing and she stated that she would look for it. During a phone interview on 7/7/15, at 2:10 p.m. the director of nursing stated that she could not locate any more documentation at this point, but would keep looking. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise Infection Control/tuberculosis program and ensure that resident and staff tuberculosis prevention are monitored and analyzed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be	21530		8/11/15

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21530	Continued From page 22 reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 23 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities regarding the lack of specific target behaviors related to the use of an anti-anxiety medication for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam (anti-anxiety medication) 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed R1 was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1-(Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused care, could be delusional, and could not stop talking. The Record of Medication Regimen Review form dated 5/19 and 6/18/15, revealed the consulting pharmacist had reviewed R1's drug regimen. However, there were no notes or recommendations found in the record regarding the lack of specific target behavior of agitation for this resident. During a telephone interview on 7/2/15, at 2:25	21530	No POC required.	

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21530	Continued From page 24 p.m. the facility's consulting pharmacist was asked if she looked for specific target behaviors with the use of psychoactive medications when reviewing resident records. The consulting pharmacist replied that she did look for the specific target behaviors and made recommendations to use specific target behaviors. The surveyor mentioned there was a Consultant Pharmacist Communication to Nursing for this resident on 2/21/15, which included the recommendation to use "patient specific Target Behaviors" for the use of several other psychoactive medications that R1 was taking at that time. The consulting pharmacist explained she had spoken with the staff at the facility about this requirement and the nurse consultants for the facility stated were working on improving the documentation of appropriate target behaviors at this facility. SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing could in-service and monitor for compliance with maintaining a functional and safe pharmaceuticals services for the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration;	21535		8/11/15

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21535	Continued From page 25 C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on record review and interview 2 of 10 residents (R1, R69) medications reviewed did not have monitoring of specific target behaviors related to the use of the anti-anxiety medication clonazepam for R1 and did not assure physician orders were followed for R69. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed the resident was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1- (Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a	21535	No POC required.	

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21535	Continued From page 26 target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused cares, could be delusional, and can't stop talking. R69's medical record lacked documentation ensuring adequate monitoring of medications. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for accuchecks, call MD (doctor of medicine) or NP (nurse practitioner) for blood glucose less than 75 or greater that 400. A review of R69's medication administration record (MAR) for June, 2015 indicated fifteen readings greater than 400 had been recorded. However, a review of progress notes for the month of June, 2015, lacked indication of MD or NP notification of blood glucose readings greater than 400. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for "Metoprolol Tartrate [medication for high blood pressure] 50 mg 8a and 8p hold for SBP [systolic blood pressure] less than 110." Review of R69's MAR for June, 2015 indicated on 6/26/15, R69's blood pressure was 109/76, and R69's medication was not held. There was no documentation the BP had been retaken and review of progress notes for June, 2015, lacked documentation regarding the low blood pressure or of any follow-up. When interviewed on 7/2/15, at 10:27 a.m., LPN-C verified the June, 2015, blood glucose results and indicated the expectation was for the	21535		

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21535	Continued From page 27 nurse to call the MD when the blood glucose was greater than 400. LPN-C also verified the low blood pressure reading on 6/26/15, and indicated the expectation was for the nurse to hold the medication per parameters, and follow up on the low blood pressure. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually	21545		8/11/15

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21545	Continued From page 28 requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure four expired medications were removed from storage for 2 of 4 medication carts reviewed, potentially affecting 3 residents (R8, R22, R40). Findings include: Review of the medication cart for the 600 hallway, on 6/29/15, at 12:35 p.m. the following were discovered: an open bottle of Levemir insulin for R8, with an opened on date of 5/12/15, (48 days prior); an open bottle of guaifenesin (cough	21545	No POC required.	

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21545	Continued From page 29 medicine), 200 milligram (mg) tablets for R22, with an unreadable direction label, and an expiration date of 3/15. Registered nurse (RN)-B verified the medications were expired and should not be used, and the direction label on the bottle of guaifenesin was unreadable. Review of the medication cart for the 500 hallway, on 6/29/15, at 12:53 p.m., the following were discovered: an open bottle of Lantus insulin for R40, with an opened on date of 5/22/15. (38 days prior.) Licensed Practical Nurse (LPN) - E verified the date and indicated the insulin was expired and should not be used. Review of R8's record indicated a physician order for Levemir solution (Insulin Detemir) Inject 28 unit subcutaneously every evening shift for diabetes. Review of R22's record indicated a physician order for guaifenesin tablet 400 mg tablet oral cough when necessary (prn.) Review of R40's record indicated a physician order for Lantus Solution (Insulin Glargine) Inject 8 unit subcutaneously one time a day related to diabetes. The Medication Expiration Procedure dated March 2015, indicated insulin vials had an expiration date of 30 days after opening. The procedure also indicated medications would be discontinued at the date of expiration the medication.	21545		

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21545	Continued From page 30 Suggested Method of Correction: The director of nursing (DON) or designee could conduct training for all staff responsible for administering medication to residents to ensure staff are following facility policies and procedures and ensure medication expirations are not occurring.The DON or designee could monitor to ensure medication expiration dates are not occurring. Time Period for Correction: Fourteen (14) days.	21545		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the bathroom was free of odors and kept in a cleanable condition for 2 of 2 residents (R65, R51) reviewed for room odors. Findings include: When interviewed on 6/30/15, at 10:46 a.m. R65 stated an odor was noted in the bathroom, and "it really smells ripe in there." At this time a stale urine odor was noted in the bathroom.	21695	No POC required.	8/11/15

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21695	Continued From page 31 On 7/2/15, at 11:05 a.m. the bathroom of R65 and R51 were noted to have a strong odor of stale urine. The director of environmental services [DES] reported the odor from the bathroom was a chronic issue. The DES stated housekeeping had informed him they clean the bathroom, and then the gentlemen in the room miss the toilet bowl when urinating. The DES reported the issue may be with the grout on the floor or the toilet. At this time the backsplash against the sink was coming away from the wall and the DES confirmed this finding. The 7 Step Daily Washroom Cleaning procedure, dated 1/1/2000, directed staff "1. Check Supplies.", "2. Empty Trash", 3. Dust Mop Floor", 4. Clean and Sanitize Sink and Tub", "5. Clean and Sanitize the Commode.", "6. Spot Clean Walls and/or Partitions" and "7. Damp Mop Floor." SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop a system to ensure the environment was clean, comfortable, without odors and checked on a routine basis. The Administrator or designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The director of facility operations or designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty-one (21) days.	21695		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights	21870		8/11/15

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21870	Continued From page 32 Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on family and resident council concerns regarding call light wait times which had the potential to impact 6 of 6 residents reviewed; R77, R9, R11, R52, R115 and R64. Findings include: Review of Resident Council Meeting Agenda and Minutes, dated 4/21/15, revealed in new business "Long call light time" with an action plan "new shipment of radios was received, we are in the process of marking them and getting them distributed to staff" This should help with the call light wait times." On 5/19/15 the Resident Council Meeting Agenda and Minutes noted in Old Business "Long call light time" with the action "New shipment of radios was received, will be addressed in nurse and nurse's aide meetings, and education of staff on spot audits." Resolution and date included "Ongoing monitoring of the situation and education of staff. Continuing date for resolution. Addressed in meetings on 5/20 and 5/21." The minutes did not include comments on resident satisfaction with call light wait time progress. The Resident Council Meeting Agenda and Minutes for 6/23/15, did not include follow up on call light wait times, despite being noted as requiring continued action and monitoring on the 5/19/15 minutes.	21870	No POC required.	

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21870	Continued From page 33	21870		

Family Townhall Minutes, dated 5/21/15, revealed "2. Nurses/aide relationship-seems to be no teamwork. They aren't responding to residents if they aren't on their wing or if it's not their job. 3. Timely call light times, long call light time during meal times. 4. Aides hide on the weekend, is there an incentive for them to not do so?" The Action Plan noted "Customer Service rounds are there to help, will continue to re-educate staff on teamwork. Upcoming staff training scheduled for June. 3. Continuing to work on this issue, again, Customer Service rounds are being done and that helps with this issue, and we have a new radio system in place to communicate more effectively. 4. There is a Manager on Duty on the weekends. Encouraged to speak with them, as well as fill out a feedback form. Talk with the nurses if this occurs in the PM [evening/afternoon]. New radio that were recently purchased should help as well." There were no more recent meetings for Family Townhall.

The facility failed to follow up on concerns related to call light wait times for R77.

A review of R77 annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use and personal hygiene and was totally dependent on staff for transfers.

On 7/1/15 at 3:15 p.m. R77 reported he waited several minutes for assistance on a recent night to help move his legs back on the bed and to get a window closed when his room was cold. R77 reported he had spoke with the administrator, current and former director of nursing about call light wait times. On 7/2/15 at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance

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21870	Continued From page 34 with getting his legs back on the bed, R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. A review of call light log for 6/21/15 to 6/27/15 revealed R77 waited over a half hour for assistance on the following instances: morning of 6/21, morning of 6/22, twice on the morning of 6/23, morning of 6/26 and morning of 6/27. The facility failed to follow up on call light wait time concerns for R9. R9's most recent quarterly Minimum Data Set [MDS], dated 5/5/15 further confirmed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15 quarterly MDS further revealed she was moderately cognitively impaired and was frequently incontinent of urine and bowel. On 6/29/15 at 5:21 p.m. a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable time. F-B reported she had observed R9 wait over an hour for help. F-B reported "some aides don't care and don't come to button calls." F-B added R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie system used to alert them of call lights. F-B reported extended call light times occurred on various shifts and had occurred on a daily basis. F-B reported she visited R9 daily at various times.	21870		

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21870	Continued From page 35 A review of call light times, for June 11th through June 24th 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11, morning and afternoon on 6/13, afternoon and evening on 6/15, afternoon of 6/16, morning of 6/17, morning of 6/18, afternoon of 6/18 and morning of 6/24. The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light on, R52 responded "sometimes it seems like forever."	21870		

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21870	Continued From page 36 Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of 6/21/15 and the afternoon of 6/27/15. Review of R115's most recent admission MDS, dated 4/21/15, revealed R115 had severe cognitive impairment and required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. On 6/30/15, at 10:37 a.m. a family member of R115, (F)-C, reported she had put her call light on when R115 was in the bathroom and sometimes waited 30 minutes for staff to help. Review of R115's call light record for 6/21 to 6/27/15 revealed the following wait times were over 30 minutes: the evenings of 6/21 and 6/22/15; and the afternoons of 6/22, 6/23 and 6/26/15. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkies. The facility had investigated call light wait times from the previous week after surveyor brought the concern to the facility's attention, but could not reach a conclusion. Any additional follow up information from the resident council concerns was requested and the administrator reported there was nothing further. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON	21870		

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21870	Continued From page 37 and administrator reported the facility should have closely monitored call lights until resolved. During an interview on 6/30/15, at 8:39 a.m. R64 who was cognitively intact, expressed frustration with attending resident council meetings because, while residents share how call lights are not being answered in a timely fashion the facility failed to adequately address the residents concern. R64 stated staff ignore the walkie talkies when they go off for a call light. R64 expressed personally seeing staff sleeping on the couches or playing cards at the table at 5:00 a.m. and turning off the call light beepers. R64 stated they had informed facility staff of these issues and knew call light issues had been discussed at several resident council meetings. R64 stated, "Going to the resident council meetings is a meet, eat, and retreat meeting, because things discussed do not change." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review or revise policies, provide education for staff regarding resident grievance process. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. Time Period for Correction:Twenty-one (21) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and	21880		8/11/15

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21880	Continued From page 38 residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by:	21880		

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21880	Continued From page 39 Based on interview and document review, the facility failed to actively resolve personal grievances expressed for 2 of 2 residents (R9, R77) regarding call light wait times. Findings include: The facility failed to resolve a grievance regarding call light wait times, expressed by R9's family. On 6/29/15, at 5:21 p.m., a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable period of time. F-B reported they had observed R9 wait over an hour for help, and stated "some aides don't care and don't come to button calls." F-B added, R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie talk system used to alert them of call lights. F-B reported visiting R9 daily, at various times, and on various shifts and had observed extended call light times during visits. On 7/2/15, at 9:08 a.m., F-B reported she had expressed concerns about call light wait times at care conferences, had spoken with the administrator and other staff about call light concerns. F-B reported at one point, after waiting an hour and a half for R9 to get assistance she "went off on them and told them that was not acceptable." F-B added "they tell us to tell them when this happens, but nothing ever changes" and "they claim they have a system, but I said clearly it is not working." F-B reported these concerns were brought up about 2-3 months ago and a facility response was never received.	21880	No POC required.	

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21880	Continued From page 40 A review of a Feedback Form dated 5/11/15, revealed F-B had expressed concerns about R9 waiting an unacceptable time for call light response. The facility noted they had educated the nursing assistants and were working on distributing more portable walkies to alert staff of call light alerts. However, there was no indication this measure had resolved the grievance, as there was no monitoring of the measure, as the facility was unable to provide documentation of monitoring. A review of call light times, for June 11 - 24, 2015 revealed R9's call light times exceeded thirty minutes on the evening of 6/11/15; on the morning and afternoon of 6/13/15; on the afternoon and evening of 6/15/15; on the afternoon of 6/16 and 6/18/15; and on the mornings of 6/17, 6/18 and 6/24/15. R9's most recent quarterly Minimum Data Set [MDS] dated 5/5/15, revealed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15, quarterly MDS further revealed R9 was moderately cognitively impaired, and was frequently incontinent of urine and bowel. The facility failed to follow up on concerns related to call light wait times for R77. On 7/1/15, at 3:15 p.m. R77 reported waiting several minutes for assistance on a recent night for repositioning and to get a window closed, when his room was cold. R77 reported he had spoken with the administrator, current and former director of nursing about call light wait times. On	21880		

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21880	Continued From page 41 7/2/15, at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed. R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented. A review of the call light log dated 6/21 to 6/27/15, revealed R77 waited over half an hour for assistance on the following dates: the mornings of 6/21,6/22, 6/26 and 6/27; and twice on the mornings of 6/22 and 6/23/15. A review of R77's annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, and was totally dependent on staff for transfers. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkie talkies. The facility had investigated call light wait times from the previous week after surveyor brought the concerns to their attention, but could not reach a conclusion. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and	21880		

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21880	Continued From page 42 new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. SUGGESTED METHOD OF CORRECTION: The director of Social Services or designee could make sure resident grievances are listened to, acted upon and that results are reported back to the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		