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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1UBM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00730

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245299**

2.STATE VENDOR OR MEDICAID NO.
(L2) **972153000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

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) **11/01/2004**

6. DATE OF SURVEY **12/17/2018** (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 **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X 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
	60			
(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:
Gail Anderson, Unit Supervisor 11/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kami Fiske-Downing, Enforcement Specialist 12/03/2018 (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
11/01/1985
(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)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2018

Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, MN 56544

RE: Project Numbers S5299032, H5299010

Dear Administrator:

On November 7, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 19, 2018 that included an investigation of complaint number H5299010. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 17, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2018, effective November 28, 2018 and therefore remedies outlined in our letter to you dated November 7, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245299

December 18, 2018

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

Dear Administrator:

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

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

Effective November 28, 2018 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1UBM

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(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

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) **11/01/2004**

6. DATE OF SURVEY **10/19/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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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) :

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(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:
Denise Erickson, HFE NE II — 11/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 12/03/2018 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
11/01/1985
(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)

DETERMINATION APPROVAL

Electronically delivered
November 7, 2018

Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, MN 56544

RE: Project Number S5299032, H5299010, H5299011, and H5299012

Dear Administrator:

On October 19, 2018, 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. In addition, at the time of the October 19, 2018 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5299010 .

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the October 19, 2018 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5299011, and H5299012 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is November 28, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (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 (488.456(b)).

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 January 19, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by April 19, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00730	A. BUILDING: _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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
2 000	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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

(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
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 15th, 16th, 17th, 18th, and 19th 2018, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition complaint unvestigations were also completed at the time of the licensing survey. An investigsation of complaints H5299010, H5299011, and H5299012, were complated. The complaint substantiated along with the (MNRule#/MN Statute) is as follows: H5299010. MN Rule/MN Statute #4658.0525 Subp. 3. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

(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
2 000	Continued From page 2 findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in	2 302		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
2 302	Continued From page 3 written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on staff interview and the review of employee records, the facility failed to ensure that all direct care staff and supervisors received the required dementia care training for 2 of 5 direct care and supervisory staff (social service designee (SSD)-A and registered nurse (RN)-C) reviewed. Also, the facility failed to provide specific training for assistance with activities of daily living (ADL) for residents with Alzheimer's disease or related disorders. Findings include: The facility provided documentation of their Alzheimer's disease and related disorders training program. The program included an undated handout titled The Confused Resident: Strategies for Quality Care. The program also included 3 videos titled The Nursing Assistant: Dementia Care, part 1, part 2 and part 3. The training program failed to address assistance with activities of daily living (ADL). Two of the five direct care staff and supervisors reviewed for completion of the facility's Alzheimer disease and related disorders training program failed to complete the required training.	2 302	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 302	Continued From page 4 RN-C was hired on 9/25/18. RN-C had not completed the dementia training videos. Social Service Designee (SSD)-A Was hired on 8/16/18. SSD-A had not completed the dementia training videos. On 10/18/18, at 11:37 a.m. director of nursing (DON) reviewed the facilities Alzheimer's disease or related disorder training program with surveyor. DON confirmed the program lacked training for providing ADLs for residents with Alzheimer's disease or related disorders. DON indicated all staff received training at time of new employee orientation (NEO). On 10/19/18, at 10:13 AM DON indicated public relations and admission director (PRAD)-A handled the NEO training the facility provided. DON reviewed the training records of employees reviewed with surveyor. DON indicated PRAD-A would be able to identify which staff had completed the required training. On 10/19/18, at 12:20 p.m. PRAD-A reviewed employee training records and confirmed SSD-A and RN-C had not completed their Alzheimer's and dementia video training, and both were currently working with residents. The facility policy titled In-Service Programs (General) revised June 2017, identified an on-going, planned education program was conducted for the development and improvement of necessary skills and knowledge for all facility personnel. Training would be performed via computer (Medcome) or in person. The policy	2 302		

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2 302	Continued From page 5 futher identified follow up of employee training would be completed monthly to identify those who had not attended the required in-services during the month and communicate expectation of in-service attendance. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could schedule an in service for all direct care staff and supervisors regarding Alzheimer's disease. The DON or designee could ensure all required staff completed the training. The quality assessment and assurance committee could audit employee records randomly to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 302		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R5) was free from the use of physical restraints. Findings include: R5's face sheet dated 10/19/18, indicated R5 had diagnoses which included vascular dementia with	2 510	Corrected	11/28/18

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2 510	Continued From page 6 behavioral disturbance, anxiety disorder and cerebrovascular disease. R5's quarterly Minimum Data Set (MDS) dated 7/18/18, indicated R5 had severe cognitive impairment and required extensive assistance of two staff for bed mobility. The MDS indicated R5 also required extensive assistance of one staff for transfers, dressing, eating, toileting, personal hygiene, and walking. The MDS further indicated R5 utilized a chair restraint daily to prevent rising and personal alarms used while in bed and in the wheelchair. R5's Physical Restraint Care Area Assessment (CAA) dated 1/30/18, indicated R5 utilized a lap tray on her wheel chair to prevent rising and self transfer attempts as R5 has history of frequent falls due to self transferring. R5 had a diagnosis of dementia and displayed severe cognitive impairment with orientation, short term and long term memory issues. R5 also had very poor safety awareness and decision making which had contributed to her past falls and the lap tray. R5's care plan revised on 2/8/18, indicated R5 used an external device for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility, physical aggression related to cognitive impairment and motor agitation. The care plan listed various interventions which included: lap tray restraint device every two hours while in wheel chair. Stand, reposition, walk in hallways and reapply. Off during meals. The care plan also indicated physician ordered restraint of lap tray, release and reposition every two hours and off at meals. The care plan further indicated to try alternative methods before using physical restraints with R5.	2 510		

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2 510	Continued From page 7 If restraint still required, place in restraint-reduction program. R5's Aide Guide Group A undated, indicated R5 required extensive assistance of one staff for eating and directed staff to release lap tray every two hours, stand up/walk, reposition, replace device and off at meals. Miscellaneous directions included the following in bold type: lap tray at all times, release and off load every two hours and off at meals. During observations of the supper meal in the main dining room on 10/17/18 at 5:30 p.m. R5 was seated in her wheelchair with a black lap tray attached to the wheelchair arms. R5 was attempting to pedal herself into the kitchen area with her feet. - at 5:55 p.m. dietary staff brought R5 a plate of food which consisted of pureed mixed fruit, carrots, pineapple chicken and rice. R5 had a glass of thickened water, milk and cranberry juice sitting on the table. R5 continued to have the black lap tray attached to her wheelchair while she tried to propel herself backwards into the kitchen area. -at 6:02 p.m. nursing assistant (NA)-E assisted R5 back to the dining room table via wheelchair with attached lap tray and encouraged R5 to begin eating her food while she gave R5 a drink of milk. - at 6:07 p.m. R5 remained seated in her wheelchair with the attached lap tray in the dining room while NA-E encouraged her to eat by telling her what she had on her plate. - at 6:14 a.m. R5 was seated in her wheelchair with the attached lap tray in the dining room about two feet from the table, when the director of nursing (DON) approached R5 and asked her	2 510		

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2 510	Continued From page 8 if she wanted to eat, R5 refused to respond. The DON tried to give R5 a drink of her cranberry juice and R5 refused. - at 6:16 p.m. the DON pushed R5 back up to the table with her lap tray in place, got a chair, sat down next to R5 and gave R5 a bite of her chicken with rice. - at 6:25 p.m. R5 was seated at the dining room table in her wheelchair with the attached lap tray while the DON continued to feed R5 her supper meal. R5's lap tray was not removed during the supper meal to release the restraint. During observations of the breakfast meal on 10/19/18 at 8:52 a.m. R5 was seated in her wheelchair with an attached lap tray, at the dining room table. Both wheelchair brakes were locked and R5's tip toes pressed up against the floor. R5 was not able to move in her wheelchair while NA-B assisted R5 to eat her breakfast. - at 8:58 a.m. NA-B gave R5 bite of her hot cereal and continued to feed R5 her breakfast meal. - at 9:00 a.m. NA-B asked R5 if she was done eating and R5 indicated she was done eating breakfast. R5 remained seated in the wheelchair with attached lap table, brakes engaged, tip toes pressed against the floor, unable to move in her wheelchair while NA-B assisted her to finish breakfast. - at 9:01 a.m. NA-B removed R5's multi-colored clothing protector, unlocked the brakes on R5's wheelchair, placed her feet on the wheelchair pedals and wheeled her out of the dining room into the hallway. R5's wheelchair brakes were locked and the lap tray was not removed during the breakfast meal to release the restraints. During observation of the noon meal on 10/19/18	2 510		

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2 510	Continued From page 9 at 12:29 p.m. R5 was seated in her wheelchair with an attached lap tray at the dining room table. R5 had both brakes locked on her wheelchair, while her tip toes pressed up against the floor. R5 was not able to move in her wheelchair while NA-G assisted R5 to eat her lunch. - at 12:32 p.m. NA-G continued to assist R5 eat her lunch while her braked remained locked on her wheelchair and her lap tray remained attached to the wheelchair. - at 12:36 p.m. licensed practical nurse (LPN)-B confirmed R5's wheelchair brakes were locked and a lap tray was attached to R5's wheelchair while NA-G fed her lunch. NA-G indicated they locked the brakes on R5 wheelchair due to her fidgeting. She verified she was not aware that R5's lap tray needed to be removed during meals. On 10/18/18 at 2:15 p.m. NA-F confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-F verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals. On 10/18/18 at 2:49 p.m. LPN-B confirmed R5 needed staff assistance for eating and all ADL's. LPN-B verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and off to the side during meals. On 10/19/18 at 11:07 a.m. the DON confirmed R5 care plan and indicated R5 needed staff assistance with meals and all ADL's. The DON verified R5 utilized a lap tray on her wheelchair as a restraint due to being a fall risk and per family request. The DON indicated the lap tray was to be removed every two hours and with meals. The DON indicated she was not aware of	2 510		

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2 510	Continued From page 10 the lap tray being removed during meals until she reviewed R5's current care plan. The DON indicated she would expect staff to follow R5's care plan as written and would expect staff to remove the lap tray during all meals and verified staff should not be locking R5's wheelchair brakes, which would also be a restraint. On 10/19/18 at 12:32 p.m. NA-B confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-B verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals. NA-B indicated she had forgotten to remove the lap tray during the meal and stated it should have been taken off during meals. NA-B also verified R5's brakes had been locked during the meal and indicated staff were not to lock the brakes on wheelchairs. Review of facility policy titled, Restraint Free Care revised on 4/1/2016, indicated physical restraints were only used when they were used appropriately to treat the residents medical symptoms and to promote an optimal level of function for the resident. The policy also indicated a restraint may never be used for the purpose of discipline or staff convenience. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop/review and or revise policies and procedures on the appropriate use of physical restraints. All appropriate staff could be educated on the process of appropriate use of physical restraints. The Director of Nursing or designee could develop a monitoring system to ensure ongoing compliance.	2 510		

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2 510	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 510		
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 observation, interview and document review, the facility failed to implement fall interventions for 1 of 2 residents (R7) reviewed for accidents, and failed to implement safe transfer requirements for 1 of 2 residents (R7) observed using a mechanical lift. In addition, the facility failed to implement safe smoking interventions for 1 of 3 residents (R40) who required staff to manage smoking materials. Findings include: FALLS R7's significant change in status Minimum Data Set (MDS), dated 4/26/18, identified R7 had severe cognitive impairment and had diagnoses	2 830	Corrected	11/28/18

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2 830	Continued From page 12 which included hemiparesis (one-sided weakness of the body), schizophrenia, and Diabetes Mellitus. The MDS indicated R7 required total assistance from staff for transfers, and extensive assistance for bed mobility, eating, toilet use, and personal hygiene. The MDS further indicated R7 had a history of falling. Review of R7's quarterly MDS, dated 7/25/18, identified R7 had moderately impaired cognition, and had diagnoses which included palliative care (managing the symptoms and side-effects of life-limiting and chronic illness), hemiparesis, schizophrenia, and Diabetes Mellitus. The MDS indicated R7 required total assistance for transfers with two or more staff. The MDS further indicated R7 had two or more falls since the last assessment. Review of R7's Care Area Assessments (CAA), dated 5/9/18, identified R7 displayed poor judgement and safety awareness with poor decision making as evidenced by attempts to self transfer, which resulted in falls. The CAA indicated R7 believed he could stand and attempted to do so in order to self transfer from the wheelchair to bed. The CAA also indicated, R7 had a history of a stroke which resulted in right sided hemiparesis, was unable to walk or stand, was a fall risk, and required a full body lift for transfers. Review of R7's care plan, last revised 10/5/18, indicated R7 was at risk for falls related to a history of falls due to self transfer attempts, as R7 believed he could still stand and walk, incontinence, balance issues, and right sided hemiparesis. R7's care plan listed various interventions which included a low bed, physical	2 830		

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2 830	Continued From page 13 therapy to assess for proper wheelchair fitting status post fall, and mechanical lift to transfer with total assist of two staff. Review of the Aide Care Guide Group B, dated 9/23/18, indicated R7 used a wheelchair, had a high-low bed, required extensive assistance with activities of daily living and transferred with total assist of two staff and a mechanical lift. During observation on 10/17/18. at 1:43 p.m. R7 was lying in a low bed with his wheelchair positioned next to the bed near the bed rail. R7's wheelchair brakes were not locked. R7 stated he was able to get himself up and to the wheelchair without help from staff, and was able to use the bathroom independently as well. R7 stated he had fallen a couple weeks ago and hit his head. R7 stated he went to the hospital and received sutures for a head wound. Review of R7's progress notes from 10/1/18, to 10/19/18, revealed: -10/1/18, R7 was found on the floor after roommate came to get the nurse. Staff applied pressure to laceration above right eye until emergency medicals services (EMS) arrived and transported to Detroit Lakes. -10/2/18, interdisciplinary team (IDT) met to review R7's fall. R7 attempted a self transfer from wheelchair to bed and fell to the floor, lacerating his forehead. R7 had right sided weakness that increased fall risk, and used a full body lift for transfers. Discussed with nursing staff and was noted R7 does not frequently apply brakes to the wheelchair and was unable to bear weight on his own. IDT decided to add auto[matic] brakes	2 830		

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2 830	Continued From page 14 (device that automatically locked the wheels whenever the person stands or sits) to wheelchair for improved safety. -10/3/18, R7's auto brakes are on order and not yet at facility. Physical therapy (PT) will assess for proper wheelchair use and positioning, as R7 was noted to slide in wheelchair as he self propels. Staff will add auto brakes when they arrive at facility. On 10/17/18, at 6:43 p.m. R7 was seated in the wheelchair and was pushed to his room by nursing assistant (NA)-H. The director of nursing (DON) followed them into the room with a mechanical lift. At 6:47 p.m. R7 was transferred to bed by NA-H and the DON, and bedtime cares were completed. At 6:55 p.m. R7's bed was lowered to the floor, he was given a call light, and NA-H placed the wheelchair next to R7's bed. NA-H and the DON left the room. R7's wheelchair brakes were not locked and the wheelchair lacked auto brakes. On 10/17/18, at 6:57 p.m. NA-H stated R7 required two staff for the majority of cares, but once in bed one staff could complete some cares as R7 could assist with bed mobility and understood instructions. She stated staff placed him in a low bed due to many self transfer attempts and risk for falls. On 10/17/18, at 7:27 p.m. NA-I stated R7 required extensive assistance with cares and was a fall risk. NA-I stated when R7 wanted to do something, like go to bed, you have to be quick as he would try to do things on his own. On 10/18/18, at 9:26 a.m. licensed practical	2 830		

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2 830	Continued From page 15 nurse (LPN)-A stated R7 required extensive assist with two staff for cares, and required a mechanical lift and two staff for all transfers. LPN-A indicated R7 was at risk for falls due to self transfer attempts. On 10/18/18, at 9:40 a.m. PT-A indicated R7 had not recently been evaluated by therapy. On 10/18/18, at 2:08 p.m. R7 was lying in bed with eyes closed. The bed frame remained elevated approximately two feet off the floor, with R7's wheelchair positioned near the bed. The wheelchair's locks were not applied and the wheelchair lacked auto brakes. NA-A entered R7's room and stated the day shift would have laid R7 in bed after lunch. NA-A stated R7 was a fall risk and should be in a low bed when occupied. NA-A lowered R7's bed to the floor and left the room as R7's wheelchair remained unlocked. On 10/18/18, at 11:14 a.m. clinical manager (CM)-A stated R7 required maximum assistance with all activities of daily living and was transferred with two staff and mechanical lift at all times. CM-A stated R7 was at risk for falls and her expectation for staff would be to follow R7's care plan and the care guides. CM-A stated R7 had a fall on 10/1/18, which required sutures at the emergency department. After the fall, staff implemented wheelchair auto brakes as an intervention to prevent future falls. CM-A indicated she was not aware the wheelchair brakes had not been placed on R7's wheelchair. On 10/19/18, at 11:42 a.m. the DON stated R7 required assistance with activities of daily living, was at risk for falls and injuries, and required two	2 830		

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2 830	Continued From page 16 staff and mechanical lift for all transfers. The DON stated after R7's fall on 10/1/18, the IDT reviewed the incident and implemented auto brakes for R7's wheelchair. She indicated maintenance updated her that the wheelchair brakes were ordered, but not available on 10/3/18. The DON stated after she learned the auto brakes would not be readily available, she verbally asked therapy to assess R7's wheelchair use. The DON confirmed R7 was not assessed by therapy, as a therapy order was not received and the proper form was not completed. She stated she would have expected the therapy assessment to have been completed more timely. The DON stated R7's bed should be in the low position when occupied, and stated she expected staff to lower R7's bed when he was lain in bed. In addition: MECHANICAL LIFT On 10/17/18, at 2:23 p.m. R7 was seated at the edge of bed with the bed approximately at knee height. R7 had an EZ-Way Stand (mechanical standing transfer equipment) positioned directly in front of him. R7 had a beige (medium) colored harness around his back, which was attached to the EZ-Way Stand's hydraulic arms. NA-I stood behind the machine's controls and attempted to raise the hydraulic arms, but the machine did not move. NA-I stated the battery had died, she removed the battery and left the room with R7 sitting at the edge of the bed, with harness behind him and feet on the stand's foot plate. As NA-I retrieved a different battery, R7 stated he used this machine often. At 2:25 p.m. NA-I returned to R7's room and placed a different battery. At 2:26 p.m. NA-I raised the arms of the	2 830		

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2 830	Continued From page 17 machine which assisted R7 to a semi-standing position. R7 held onto the machine's hand grips with his left hand, as he was unable to hold on to the machine with his right hand. The EZ-Stand's harness was under R7's left arm, but R7's right elbow rested on the middle of the harness on the right. The harness buckle strap was closed loosely around R7's waist. As R7 was raised by the standing machine, NA-I stood behind the machine and did not attempt to tighten the harness's buckled strap, around R7's torso. NA-I then moved the EZ-Stand, with R7 holding on to the machine with one hand and his right elbow pushing against the harness on the right, towards R7's bathroom. NA-I stopped before R7's bathroom, removed R7's pants and an incontinent brief, and pushed R7 and the machine into the bathroom. NA-I then pushed R7 into the bathroom. As R7's buttocks neared the toilet, NA-I had to raise R7 higher in the EZ-Stand to get his buttocks over the arm rest of the toilet. R7 remained holding onto the machine with only his left hand and his elbow rested in the harness. NA-I then lowered R7 onto the toilet and left him attached to the EZ-Stand machine and left the bathroom. At 2:29 p.m. NA-I stated she worked for a nursing agency, and had worked at the facility for two months. At 2:32 p.m. R7 stated he was done using the toilet and NA-I entered R7's bathroom. NA-I used the machine's controls and raised R7 to a semi-standing position. NA-I completed perineal cares and pulled the EZ-Stand machine, with R7, out of R7's bathroom. As NA-I maneuvered the EZ-Stand towards a bath chair, the harness around R7 began sliding up his back. R7's right elbow remained positioned on the harness, with his right hand pulled closely to his chest. The harness buckle had moved up from his lower	2 830		

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2 830	Continued From page 18 abdomen to his upper chest and R7's right foot was positioned off of the foot plate. At 2:34 p.m. NA-I lowered R7 onto a bath chair. When R7 was seated in the bath chair, the lower border of the EZ-Stand harness was around R7's upper back, with the upper border of the harness at R7's upper neck. Near R7, in the bath chair, was R7's wheelchair. In the seat of the R7's wheelchair was a sling for the EZ-Lift (mechanical lifting transfer equipment) machine. At 2:37 p.m. NA-I removed the rest of R7's clothing and placed a bath robe on R7 and pushed the bath chair from R7's room to the tub room. On 10/17/18, at 2:57 p.m. R7 was seated in the bath chair, covered in the bath robe, back in his room after a bath. The EZ-Stand machine was again positioned in front of him. At 2:59 p.m. NA-I picked up the beige EZ-Stand harness and placed it behind R7 in the same position as above, except positioned the right side of the harness onto R7's right elbow, which was inside the bathrobe's sleeve. NA-I buckled the harness around R7's abdomen and pulled the buckle strap tighter. NA-I placed R7's feet onto the foot plate and applied the calf strap, then used the controls to raise the EZ-Stand's hydraulic arms. R7 stood up, while holding onto the machine's hand grips using his left hand, as his right hand was inside the bathrobe. As the machine assisted R7 to a standing position, the harness buckle strap became looser, and NA-I did not attempt to pull the buckle's strap tighter. At 3:05 p.m. R7 was lowered by the machine onto the edge of the bed. NA-I removed the machine's harness and assisted R7 to lay flat and assisted R7 to dress. At 3:09 p.m. NA-I pushed R7's wheelchair near the bed and locked the wheels. NA-I then picked up an EZ-Lift sling that was on	2 830		

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2 830	Continued From page 19 the wheelchair's seat and placed the sling on a stand near the bed. At 3:10 p.m. NA-I moved the EZ-Stand machine to the side of R7's bed near the bed rail. NA-I tried to assist R7 to sit up at the edge of the bed, but R7 was unable to assist in the bed mobility. NA-I then placed a transfer belt on R7 and raised the head of R7's bed. NA-I then grabbed around R7's upper back with the right arm and held onto the transfer belt with the left arm and tried to assist R7 to an upright seated position at the side of the bed. R7's right side remained slumped back and leaned to the left. NA-I placed the EZ-Stand harness around R7's back, while holding R7 in a seated position utilizing the transfer belt. At 3:14 p.m. R7 stated "I'm not sitting right" as NA-I continued to attempt to place the machine's harness. At 3:16 p.m. NA-I attached the harness to the EZ-Stand machine and stated "you are not seated well", and gave R7 instructions to hold onto the machines handle. At 3:18 p.m. NA-I started to raise the EZ-Stands mechanical arm, attempting to assist R7 to sit straight in front of the machine. At 3:20 p.m. NA-H knocked and entered R7's room. NA-H stated to NA-I "we can lay him down and use the hoyer [EZ-Lift], since he is tired". At 3:22 p.m. NA-H asked R7 if he preferred to lay in bed and nap and R7 answered "yes". NA-I and NA-H removed the EZ-Stand harness and assisted R7 to lay down, and the two staff boosted R7 up in bed, lowered the bed and left the room. On 10/17/18, at 6:57 p.m. NA-H stated R7 required two staff for the majority of cares, but once in bed one staff could complete some cares as R7 could assist with bed mobility and understood instructions. NA-H stated if R7 wanted to use the commode (portable toilet) or	2 830		

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2 830	Continued From page 20 toilet staff could use the EZ-Stand to transfer him. NA-H stated R7's abilities to assist varied, and he transferred mostly with two staff and the EZ-Lift. NA-H indicated the use of the EZ-Stand depended on how R7 was doing that day, and if he was too tired, staff would use the EZ-Lift. NA-H stated staff were trained on the mechanical transfer equipment on hire, and thought maybe annually as well. NA-H stated if staff had questions on R7's care they could refer the the care guides or the nurses. On 10/17/18, at 7:27 p.m. NA-I stated R7 required extensive assistance with cares and was a fall risk. NA-I stated when R7 wanted to do something, like go to bed, you have to be quick as he would try to do things on his own. NA-I stated R7 transferred mostly with two staff and the EZ-Lift, but at times used the EZ-Stand. NA-I stated she used the EZ-Stand with R7 at least once a shift, as she could use the standing transfer equipment with only one staff present. NA-I stated R7 struggled with the EZ-Stand today, and if the transfer does not go well with the Stand we would use the Lift. NA-I stated it was good for R7 to use the standing transfer machine as he would get to exercise his legs, and when he used the Lift his legs just lay there in the air. NA-I indicated R7's care plan would instruct how to transfer R7, or the care guide. NA-I checked for the care guide and could not find one. At 7:36 p.m. NA-I found her care guide at the nurse's station and confirmed R7 was to be transferred with two staff and the hoyer [EZ-Stand]. NA-I indicated when she started at the facility other NAs showed her the EZ-Way machines, and she had used the EZ-Way machines at a facility in the past. NA-I indicated she was not aware if a competency check was	2 830		

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2 830	Continued From page 21 completed on the facility's EZ-Way Lift or Stand. Review of the facility provided EZ-Way, Inc. EZ Way Stand Operator's Instructions, undated, indicated "Transferring the patient: Attach harness 1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3 inches below the underarm. 2) For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. ... Raise the patient 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. 2) With hand control in-hand stand beside the patient. ....Press the up button. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso." On 10/18/18, at 9:40 a.m. PT-A stated when residents are first admitted they are screened by therapy to see if they required the transfer lift or stand. PT-A stated after, nursing staff will update therapy if the resident had changed and we would get an updated screen to see if new recommendations were needed. PT-A stated R7's last screen was some time ago and he would have to check R7's records. PT-A stated a harness placement that was not under both arms, or having one arm under clothing while transferring would not be safe. At 10:14 a.m. PT-A confirmed R7's last safety screen with transfers was 11/17, and therapy's recommendation would be to continue to use EZ-Lift and two staff for all transfers for R7's safety. Review of Pro Rehab Nursing Referral For	2 830		

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2 830	Continued From page 22 Therapy Screen, dated 11/27/17, indicated R7 was screened for safety on 11/13/17, due to two falls and self transfers. The Screen indicated R7 was now assist of two staff with hoyer [EZ-Lift] for all transfers in room. On 10/18/18, at 11:14 a.m. clinical manager (CM)-A stated R7 required maximum assistance with all activities of daily living and was transferred with two staff and mechanical lift at all times. CM-A stated R7 was at risk for falls and her expectation for staff would be to follow R7's care plan and the care guides and to use the mechanical lift for all transfers. On 10/19/18, at 11:42 a.m. the DON stated R7 required assistance with activities of daily living, was at risk for falls and injuries, and required two staff and mechanical lift for all transfers. The DON stated she was aware R7 was transferred with the EZ-Stand by NA-I. DON indicated she had reviewed the proper use of the EZ-Stand equipment with NA-I last evening after R7's transfers. The DON stated all NAs at the facility would be completing full education on EZ-Stand use. On 10/19/18, at 1:04 p.m. during a phone interview with EZ-Way product specialist (EWPS)-A stated all EZ-Stand training included placing the EZ-Stand harness under both arms always. She stated the arms always have to be over the harness, or there would be a risk of slipping out of the harness and falling. EWPS-A stated staff should always tighten the harness as the EZ-Stand's arms are raised, as the harness will become looser as the resident stands. Review of the facility policy titled,	2 830		

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2 830	Continued From page 23 Accidents/Falls-HDGR [Health Dimensions Group], last revised 2/14, indicated the facility strived to promote safety by providing interventions to prevent avoidable accidents. The policy indicated the resident's individualized care plan was to be updated with any changes or new interventions post fall, communicated to appropriate staff, and implemented. Post fall incidents would have continued follow-up on the 24 hour report charting for 72 hours so as to continue assessment for possible injuries as well as to further evaluate the interventions put into place. Review of the facility policy titled, Lift-Sit to Stand, last revised 3/1/14, indicated staff would refer to instructions for the facility equipment to be used. Staff must be trained in lift use and safety precautions. The policy further indicated 1. Obtain correct lift and sling. 8. Transfer according to manufacture direction guidelines. SMOKING R40's significant MDS dated 7/10/18, identified R40 had intact cognition, had diagnoses which included major depression, macular degeneration (a condition which causes visual impairment), conversion disorder with seizures or convulsions (a mental condition in which a person has blindness, paralysis, or other nervous system (neurological) symptoms that cannot be explained by medical evaluation). R40's smoking assessment dated 9/26/18, identified R40 was able to move to and from the designated smoking area with wheelchair, able to safely use lighter or matches and safely extinguish cigarette, however; forgets to remove oxygen before going out at times and was	2 830		

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2 830	Continued From page 24 observed smoking cigarette in room recently. R40's smoking assessment noted,"Staff remind her to remove O2 (oxygen) prior to smoking at times. Smoking materials to be kept at the nurses station." R40's care plan revised 10/1/18, identified as a focus: R40 had been assessed to be safe to smoke independently but staff to manage smoking materials due to an incident of smoking in her room. R40 utilized oxygen and was able to remove it independently prior to going outside to smoke. The care plan interventions directed smoking material to be stored at nurses station in the locked medication room. R40 was to ask for a cigarette and lighter from the nurse when desired. Staff to ensure oxygen tank was removed prior to going outside to smoke. The facility form titled Aid Care Guide dated 9/23/18, identified R40 as a current independent smoker, with smoking materials housed at the nurses station and resident to ask nurse when wanting to go out to smoke. Review of R40's progress notes from 7/10/18 through 10/12/18 identified: - 8/3/18, R40 noted to be outside of facility under the front door canopy smoking while oxygen was on. -9/27/18, the social services designee (SSD) reported R40 found smoking in room. -9/27/18, A follow up note identified- smoking materials removed from residents room (cigarettes and lighter),- Reviewed smoking policy- Educated about no smoking in the facility at any time-Explained the nurses are now to house her smoking materials locked at the nurses station-Resident was to request	2 830		

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2 830	Continued From page 25 cigarettes and lighter from nurses and they will disperse the items- Oxygen was to be removed by the nurse or R40 prior to going outside to smoke -Lighter was to be returned to the nurse when done smoking. -9/28/18, Nurse observed R40 clicking lighter in hand while sleeping. Lighter was removed. An incident report dated 9/27/18, described the incident as follows: Report by SSD, R40 was smoking in her room. R40 admitted to smoking in her room because she thought no one would know. The lighter and cigarettes were taken from R40. No injury noted. During an interview on 10/15/18, at 11:54 a.m. R40 indicated she was able to smoke independently without restrictions, at the facility designated smoking area outside of the facility. On 10/17/18, at 2:51 p.m. R40 propelled self with electric wheelchair to R33's room which was empty and then to the dining room. R40 exited the dining room and requested surveyor to come with her outside while she smoked. When R40 reached the front entry door, she removed the oxygen tank from her wheelchair. The director of nursing (DON) asked R40 where she had obtained the smoking materials, to which R40 responded, "from my daughter, so I have my own." The DON explained R40's smoking materials were to be kept by the nurse. R40 became angry and continued outside to smoke. When R40 reached the smoking area outside of the facility R40 reached into her sweatshirt pocket and produced a pack of New Port cigarettes which held 2 cigarettes and a lighter. R40 lit the cigarette and placed the lighter back into the pack and into her sweatshirt pocket.	2 830		

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2 830	Continued From page 26 On 10/18/18, at 9:09 a.m. R40 independently returned from the outside smoking area to the facility with the electric wheelchair. R40 stopped on the left side of the facility office where she had left the oxygen tank. R40 reapplied the oxygen tubing with the nasal cannula in the nose and tubing behind the ears. R40 then placed the oxygen tank on the foot rest between her feet. R40 propelled herself in the electric wheelchair down the hall and directly to her room. R40 did not approach facility staff to return the smoking materials. On 10/18/18, at 11:00 a.m. R40 independently returned from the outside smoking area to the facility with the electric wheelchair. R40 propelled herself directly to her room and reapplied the oxygen tubing and tank which was left in the room prior to exiting the building to smoke. R40 did not return smoking materials to facility staff. On 10/18/18, at 11:22 a.m. LPN-B identified she did not work with R40 and did not manage smoking materials for her. On 10/18/18, at 11:26 a.m. LPN-A verified she stored R40's smoking materials in the medication cart and would give them to R40 when she asked. LPN-A identified R40 had not asked for the smoking materials today. LPN-A looked through he medication cart and was unable to find R40's cigarettes and lighter. LPN-A then looked in the medication room, where only an unopened pack of New Port cigarettes were found on the counter but no lighter. LPN-A indicated R40 typically comes to staff to ask for cigarettes and the lighter but does not return the items causing staff to ask R40 to return them.	2 830		

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2 830	Continued From page 27 LPN-A indicated the New Port cigarettes were R40's, however; she was unsure where the lighter was. LPN-A indicated it had been a while since R40 had asked her for smoking materials and verified she had not given R40 cigarettes or a lighter today. On 10/18/18, at 12:38 p.m. R40 propelled herself from the dining room to the front entry of the facility where she removed her oxygen tubing and tank. R40 propelled the electric wheelchair outside to the designated smoking area. R40 reached into the right pocket of her gray sweatshirt and produced a metal cigarette case and lighter. R40 independently lit the cigarette. On 10/18/18, at 2:19 p.m. LPN-A identified she was the only staff member during this shift who had access to the R40's smoking materials. R40 had not requested smoking materials today and was not given any. LPN-A indicated she was unaware of the reason R40's smoking materials were managed by nursing. LPN-A stated, "it must be the facility policy." On 10/18/18, at 2:26 p.m. NA-A identified the nursing assistants did not assist R40 with smoking. NA-A identified R40 was independent to propel herself outside to smoke after the nurse provided her with cigarettes and lighter. NA-A indicated R40 was able to take the pack of cigarettes and lighter and upon return from outside needed to return the smoking materials to the nurse. On 10/18/18, at 3:47 p.m. Registered nurse (RN)-A indicated R40 independently propelled self out of the building to smoke when R40 chooses. RN-A indicated R40 did not come to	2 830		

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2 830	Continued From page 28 RN-A to ask to smoke. On 10/18/18, at 3:52 p.m. R40 propelled the electric wheel chair to her room. R40 picked up the gray sweat shirt and stated," I was going out and I left all my goodies here (indicating cigarettes and lighter)." R40 picked up the gray sweat shirt and continued outside to the smoking area. R40 stated she is free to go outside and smoke independently, has no restrictions with smoking and doesn't need to tell anyone she is going. On 10/18/18, at 3:54 p.m. the DON verified R40's smoking assessment dated 9/26/18, and care plan as accurate and current. The DON verified R40 was required to turn in the cigarettes and lighter because R40 was found smoking in her room on 9/27/18, and it was a concern that R40 may try again to smoke in the facility and also with oxygen in the room. The DON indicated the nurse was responsible for R40's smoking materials because the items were locked in the medication cart or room and only the nurse has access to these areas. The DON verified R40 had cigarettes and a lighter in her possession on 10/17/18, which she had not received from the nurse. On 10/19/18, at 9:04 a.m. the DON stated R40 did have a metal cigarette case and lighter on her person last evening and did give them to nursing with out complaint. On 10/18/18, at 3:44 p.m. NA-C indicated R40 was independent to go outside to the smoking area and smoke independently. NA-C was not aware of any restrictions for R40's smoking.	2 830		

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2 830	Continued From page 29 The undated facility policy titled Resident Smoking Policy, identified the Purpose: To provide a safe smoking program that respects the rights and dignity of all Residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure safe resident mechanical lift transfers, fall interventions, and safe smoking interventions were consistently implemented. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be	2 840		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: _____ B. WING _____	C 10/19/2018

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2 840	Continued From page 30 checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 3 residents (R38) who were dependent upon staff for activities of daily living. Findings include: R38's admission Minimum Data Set (MDS), dated 9/28/18, identified R38 had diagnoses	2 840	Corrected	

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2 840	Continued From page 31 which included dementia, heart failure and seizure disorder. The MDS identified R38 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, transfers, personal hygiene, dressing and toileting. Further, the MDS identified R38 was occasionally incontinent of bowel and frequently incontinent of bladder, and was not on a bowel or bladder toileting program. R38's care area assessment (CAA) dated 9/28/18, indicated R38 was incontinent of bowel and bladder, was unable to make her needs known, unable to sit on the toilet and was incontinent of bowel and bladder at all times. The CAA also indicated R38 had diagnoses of congestive heart failure and was receiving diuretics to keep fluid off of her extremities and heart, which increase her risk for incontinence. The CAA further indicated R38 was at risk for skin breakdown and odor related to incontinence and staff would anticipate R38's needs. R38's Bowel and Bladder Functional Evaluation dated 9/25/18, indicated R38 had incontinence of bowel and bladder, unable to feel urge/sensation to void/defecate and had functionally incontinent related to dementia, impaired mobility and dependent on staff for all cares, ADL's and staff to check/change. R38's current care plan revised on 10/15/18, identified R38 had self care deficits related to urinary incontinence, constipation, dementia, weakness, generalized pain and malnutrition. The care plan listed various intervention which directed staff to check/change for incontinence upon rising, before and after meals, at bedtime and with night rounds and as needed.	2 840		

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2 840	Continued From page 32 Review of Aide Guide for Group A undated, indicated R38 was incontinent of bowel/bladder and directed staff to check/change upon rising, before and after meals, at bedtime and check/change with rounds at night. Continual observations were conducted on 10/17/18 from 5:08 p.m. to 7:55 p.m. - at 5:08 p.m. R38 was seated in her Broda chair in her room watching TV. - at 5:15 p.m. R38 remained the same and the director of nursing (DON) stopped in room, peaked at R38 and left the room. - at 5:29 p.m. DON wheeled R38 out of her room via Broda chair down to the dining room and pushed her up to the dining room table. - at 5:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of her thickened water. - at 5:59 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots. - at 6:12 p.m. NA-E continued to assist R38 to eat her supper. - at 6:20 p.m. NA-E asked R38 if she was done eating, wiped her mouth, removed her clothing protector from her chest area, wheeled R38 out of the dining room via Broda chair and back to her room. NA-E reclined R38's Broda chair back slightly, placed call light, made resident comfortable and left her room. - at 6:48 p.m. R38 remained in her room seated in her Broda chair and was watching TV. - at 7:02 p.m. R38 remained in her room seated in her Broda chair, TV on and R38's eyes were closed while she rested. - at 7:05 p.m. activity staff entered R38's room,	2 840		

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2 840	Continued From page 33 asked if she want to come to activity, activity staff wheeled R38 out of her room via Broda chair down to the activity room where they were singing and having bible class. - at 7:22 p.m. R38 remained seated in her Broda chair while she continued to listen to singing in the activity room. - at 7:38 p.m. activity staff pushed R38 back to her room via Broda chair and left the room. - at 7:41 p.m. R38 remained in her room seated in her Broda chair and R38's eyes were closed while she rested. - at 7:45 p.m. NA-D enter R38's room with full mechanical lift and began to assist R38 to get ready for bed while NA-E entered the room to help. - at 7:51 p.m. NA-D and NA-E continued to assist R38 to get ready for bed by washing her up and putting her pajama's on her upper body. - at 7:55 p.m. NA-D and NA-E positioned the full mechanical lift over R38, hooked R38 to the mechanical lift and transferred her from her Broda chair to the bed. NA-D and NA-E proceeded to roll R38 from side to side, removed the lift sling, NA-D removed R38's pants, NA-E confirmed R38 was incontinent of bowel and bladder and they proceeded to change R38's incontinent products. During observation R38's buttocks was noted to be bright red around the rectal area which extended to the outer edges of her buttock crease to be more pink with no open areas noted. R38 had not been check/changed for a total of 2 hours and 47 minutes even though she was dependent upon staff for incontinence care and was at risk for skin breakdown. On 10/18/18 at 11:54 a.m. NA-F confirmed R38 was routinely incontinent of bowel and bladder and needed to be checked/changed every two	2 840		

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2 840	Continued From page 34 hours. On 10/18/18 at 12:16 p.m. licensed practical nurse (LPN)-B confirmed R38 was routinely incontinent of bowel and bladder and had to be checked and changed every two hours, an was at risk for skin breakdown. On 10/19/18 at 10:46 a.m. the DON verified R38 was at risk for skin breakdown and pressure ulcers and would expect staff to check/change as identified by the care plan. On 10/18/18 at 2:51 p.m. NA-E called via phone call confirmed R38 required assistance of two staff with all cares and was incontinent of bowel/bladder and wore incontinent products. NA-E indicated R38 required staff to checked/changed her every two hours. NA-E verified R38 had not been checked/change before or after the supper meal and stated we tried to get in there right away. Review of facility policy titled, Bowel and Bladder Management revised on 11/16, indicated there's a system to ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure incontinent residents are provided incontinent cares or toilet use timely and provided appropriate incontinent products. The DON or designee could develop monitoring systems to ensure ongoing compliance.	2 840		

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2 840	Continued From page 35 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive assessment and implement appropriate interventions to prevent a decline or maintain current range of motion (ROM) abilities for 1 of 2 residents (R18) reviewed with limited ROM. Findings include: R18's admission Minimum Data Set (MDS) dated 8/23/18, identified R18 had diagnoses which included; dementia, hemiplegia (weakness on one side of the body), and aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to	2 895	Corrected	11/28/18

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2 895	Continued From page 36	2 895		

read or write). R18's MDS further identified R18's cognition was severely impaired and required extensive assistance with bed mobility, dressing, eating, personal hygiene, and required total assistance for transfers, locomotion, and toilet use. R18's MDS also identified no rejection of care, and a functional limitation in range of motion on one side of her upper and lower extremities.

Review of R18's Care Area Assessments (CAA) dated 8/29/18, identified R18 rarely/never verbalized her needs and was dependent on staff for all activities of daily living (ADL) due to her cognitive impairment and deficits from her stroke years ago. The CAA further identified, R18 had limited understanding of others and would have physical behaviors during cares and verbal behaviors of yelling out during cares as she did not understand, and staff may have to re-approach. The CAA also identified R18 had partial or total loss of arm movement, functional limitation in range of motion, hemiplegia, and inability to perform ADLs without significant physical assistance.

R18's care plan, last revised 10/19/18, identified R18 had decreased mobility of right hand due to hand in flexed position. R18 was dependent on staff for all ADLs and mobility. R18's ADLs portion of care plan listed FMP as allows. R18's behaviors section of the care plan indicated R18 had verbal and physical behaviors during cares related to severe cognitive impairment and limited understanding due to her diagnosis of dementia and deficits as a result of her cardiovascular accident (CVA) (stroke). Target behaviors included; hitting slapping and attempt to bite during cares. She would yell out during

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2 895	Continued From page 37 cares, often yelling "owa". Husband stated this was not pain related but feels she yells "owa" because someone is touching her and she doesn't understand. Various interventions were listed which included; "give her something to occupy her left hand when providing cares, such as a washcloth, to distract her from physical behaviors during care". R18's Aide Care Guide Group B, dated 9/23/18, identified R18 required extensive assistance from one to two staff, was non-ambulatory, and had a tendency to hit out and yell with cares. The guide instructed staff to try and place something in her left hand to hold during cares, and was a high risk for skin concerns. Review of the physician progress note dated 5/5/18, indicated it was a nursing home admission history and physical. Under physical exam the note indicated "Musculoskeletal: Right hand somewhat flexed, right hemiparesis". On 10/16/18, at 9:44 a.m. R18 was observed seated in a wheelchair with eyes opened. R18's right hand was clenched into a fist, and no device or material were noted in the right hand. R18's right foot was flexed and rested against the foot rest of the wheelchair. Family member (FM)-A was present and stated R18's right hand had been like that for a long time. FM-A stated he visited daily, and was not aware if R18 had any ROM exercise program. On 10/16/18, at 2:10 p.m. R18 was lying on her back in bed with her eyes open and the television was on. R18's right hand remained clenched into a fist.	2 895		

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2 895	Continued From page 38 On 10/17/18, at 1:18 p.m. R18 was lying on her back in bed with the head of the bed raised, eyes were open and the television was on. R18's right hand remained clenched into a fist. On 10/17/18, at 5:13 p.m. R18 was seated in the wheelchair, which was slightly reclined, at the dining room table. R18's right hand was positioned in her lap and her right hand remained clenched in a fist. R18's right foot remained flexed and rested on a pillow on the footrest of the wheelchair. R18's progress notes reviewed from 8/1618, to 10/16/18, revealed the following: -8/29/18, R18 yelled out when certified occupation therapy assistant (COTA) attempted to do passive ROM (PROM) then refused any further ROM. R18 would continue with current FMP, PROM bilateral lower extremities (LE) and upper extremities (UP) 3-5 times per week. R18 was new to program that week. -9/5/18, R18 denied pain when left arm lifted, and yelled ow when attempted to mover her right hand. "[S]he holds her right hand together tightly". -9/12/18, therapy note; R18 was provided with a different wheelchair for use in facility to improve posture and sitting tolerance. -9/14/18, R18 refused FMP this date. -9/18/18, R18 refused to let COTA touch them without yelling out this date, so PROM not done this date per R18's refusal.	2 895		

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2 895	Continued From page 39 -9/19/18, refused FMP this date. -9/25/18, PROM B LE and UE. -9/28/18, "PROM B LE and UE 1 to 3 times per week. Active participation. Continue no change." -10/2/18, R18 not seen this date for FMP due to sleeping. -10/3/18, R18 was asleep and therefore was not seen for FMP. -10/5/18, R18 was sleeping when COTA attempted to see. -10/10/18, refused FMP this date. -10/16/18, PROM bilateral LE and left elbow and wrist. On 10/18/18, at 10:08 a.m. physical therapist (PT)-A indicated R18 was admitted for long-term care and did not have admission therapy orders. PT-A stated, if residents were admitted to long term care, they would be screened for any concerns. PT-A stated he would check therapy records for R18's screen. On 10/18/18, at 10:33 occupational therapist (OT)-A stated R18 was admitted for long term care without therapy orders. OT-A indicated, therapy would not see the newly admitted resident without therapy orders, and would depend on nursing staff to notify therapy staff if a screen would be needed for a possible functional maintenance program (FMP). OT-A stated OT would screen residents with limited ROM or possible contractures (condition of fixed high	2 895		

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2 895	Continued From page 40	2 895		

resistance to passive stretch of a muscle) to place them on a FMP to complete stretching and ROM to decrease any further contraction. OT-A confirmed R18 had only one screen from therapy for a wheelchair assessment. OT-A confirmed R18 was on a FMP, but no documentation of a screen for FMP was available.

On 10/18/18, at 10:41 a.m. OT-A entered R18's room and evaluated R18's right hand for possible contractures. OT-A opened R18's right hand and R18's skin was pale/white in appearance and appeared macerated (moist, soft and in a state of deterioration). OT-A held R18's hand open and indicated the palm and finger area had to dry out. OT-A stated R18 would benefit from a splint or hand roll. At 10:44 a.m. FM-A entered R18's room and stated R18 used to have a roll or a wash cloth in her right hand at a previous facility. OT-A evaluated R18's right foot and indicated R18 would benefit from a brace to the right foot.

On 10/18/18, at 10:45 a.m. OT-A stated R18 was at risk for worsening contractures, and confirmed R18 had not had a splint, brace, or hand roll while at the facility. OT-A stated she would have expected the certified occupational therapy assistant (COTA) responsible for administering R18's FMP to have updated therapy on the state of R18's right hand and R18's refusing FMP to the right hand. OT-A confirmed therapy had not received any concerns related to R18, other then her wheelchair screen.

On 10/18/18, at 2:46 p.m. during an phone interview with COTA-A, she stated she was responsible for completing R18's FMP and was scheduled for 1 to 3 times per week. COTA-A indicated all documentation for the FMP was in

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2 895	Continued From page 41 R18's progress notes. COTA-A indicated she would work with R18 usually once per week. She stated, normally if she could work with R18 it was to complete her lower extremity ROM. COTA-A stated the last time she worked with R18, she did allow her to complete ROM on R18's left upper extremity. COTA-A stated she had never been able to touch R18's right upper extremity due to R18 stating no, or would yell at her. She indicated she would report to nursing or therapy any changes with R18, or anything new. COTA-A indicated R18 was admitted without therapy orders, so she assumed the facility had a plan for R18. COTA-A stated she had not seen R18 with any device or wash cloth in her right hand. On 10/18/18, at 11:06 clinical manager (CM)-A stated if nursing staff noted a contracture, they would update the nurse, and the nurse would fill out a therapy screen and get physician orders for therapy. CM-A stated R18 had diagnoses of CVA and hemiplegia, and was at risk for contractures. On 10/18/18, at 2:16 p.m. nursing assistant (NA)-J stated she regularly worked with R18. NA-J stated in the mornings, she would have to open R18's right hand and wash it with soap and water due to an odor. NA-J stated staff would at times place a wash cloth in R18's left hand so she would have something to hold on to. On 10/19/18, at 11:27 a.m. director of nursing (DON) stated if a resident was admitted with a contracture, she would expect something to be in place to address it. She would have expected the staff responsible for R18's FMP to update nursing or therapy of R18's refusal to work with the right hand so a screen could have been completed.	2 895		

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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
2 895	Continued From page 42 Review of facility policy titled Rehabilitation Services Orders dated 4/1/08, indicated the facility provided physical, occupational, or speech therapy to attain or maintain function and/or prevent decline with a physician-ordered treatment plan. A policy for identifying contractures, splint or brace use was requested and none were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide a resident restorative nursing program, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of the restorative nursing program to ensure the residents programs are completed consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
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	2 900		11/28/18

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2 900	Continued From page 43 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 ensure timely assistance with repositioning for 1of 1 resident (R38) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: R38's admission Minimum Data Set (MDS), dated 9/28/18, identified R38 had diagnoses which included dementia, heart failure and seizure disorder. The MDS identified R38 required extensive assistance of two staff for bed mobility and transfers. The MDS further identified R38 was at risk for the development of pressure ulcers and listed various treatments which included pressure relieving devices for chair and bed. R38's care area assessment (CAA) dated 9/28/18, indicated R38 was at risk for and had history of skin break down related to pressure to coccyx and open area, which had been resolved and remained at risk for further skin breakdown. The CAA also indicated R38 utilized a pressure relieving mattress and pressure relieving pad in wheelchair, needed staff assistance for all mobility, was unable to move self in bed and was able to participate with staff to reposition. The CAA further indicated R38 was at risk for pressure ulcers related to malnutrition, chronic or	2 900	Corrected	

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2 900	Continued From page 44 end stage renal, liver, heart disease, dementia, immobility and staff were to ensure to do repositioning. R38's Braden Scale for Predicting Pressure Sore Risk form, dated 9/25/18, identified R38 was at high risk for the development of pressure ulcers, skin was often very moist, was chair fast, had very limited mobility, probably inadequate nutrition and had a problem of friction and shearing. The form indicated R38 was at risk for skin breakdown and required total assistance from staff for all cares, activities of daily living (ADL's) and mobility. R38's current care plan revised on 10/15/18, identified R38 had self care deficits and skin breakdown related to dementia, incontinence, impaired mobility, weakness, generalized pain, malnutrition and dependent on staff for all cares. The care plan directed staff to turn and reposition upon rising, before and after meals, at bedtime and with rounds during night hours. Review of Aide Guide for Group A undated, indicated R38 was high risk for skin breakdown and directed staff to turn and reposition upon rising, before and after meals, at bedtime and with rounds during night shift. Continual observations were conducted on 10/17/18 from 5:08 p.m. to 7:55 p.m. - at 5:08 p.m. R38 was seated in her Broda chair in her room watching TV. - at 5:15 p.m. R38 remained the same and the director of nursing (DON) stopped in room, looked at R38 and immediately left the room. - at 5:29 p.m. DON wheeled R38 out of her room via Broda chair down to the dining room and	2 900		

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2 900	Continued From page 45 pushed her up to the dining room table. - at 5:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of her thickened water. - at 5:59 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots. - at 6:12 p.m. NA-E continued to assist R38 to eat her supper. - at 6:20 p.m. NA-E wiped R38's mouth, removed her clothing protector from her chest area, wheeled R38 out of the dining room via Broda chair and back to her room. NA-E reclined R38's Broda chair back slightly, placed call light, made resident comfortable and immediately left the room. - at 6:48 p.m. R38 remained in her room seated in her Broda chair and was watching TV. - at 7:02 p.m. R38 remained in her room seated in her Broda chair, TV on and R38's eyes were closed while she rested. - at 7:05 p.m. activity staff entered R38's room, asked if she want to come to activity, activity staff wheeled R38 out of her room via Broda chair down to the activity room where they were singing and having bible class. - at 7:22 p.m. R38 remained seated in her Broda chair while she continued to listen to singing in the activity room. - at 7:38 p.m. activity staff pushed R38 back to her room via Broda chair and left the room. - at 7:41 p.m. R38 remained in her room seated in her Broda chair and R38's eyes were closed while she rested. - at 7:45 p.m. NA-D enter R38's room with full mechanical lift and began to assist R38 to get ready for bed while NA-E entered the room to help.	2 900		

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2 900	Continued From page 46 - at 7:51 p.m. NA-D and NA-E continued to assist R38 to get ready for bed by washing her up and putting her pajama's on her upper body. - at 7:55 p.m. NA-D and NA-E positioned the full mechanical lift over R38, hooked R38 to the mechanical lift and transferred her from her Broda chair to the bed. NA-D and NA-E proceeded to roll R38 from side to side, removed the lift sling, NA-D removed R38's pants. NA-E confirmed R38 was incontinent of bowel and bladder and they proceeded to change R38's incontinent products. During observation R38's buttocks was noted to be bright red around the rectal area which extended to the outer edges of her buttock crease to be more pink with no open areas noted. R38 had not offered to reposition before and after meals as directed by her care plan and was unable to reposition herself independently. R38 had not been repositioned for a total of 2 hours and 47 minutes and was at high risk for pressure ulcers. On 10/18/18 at 11:54 a.m. NA-F confirmed R38 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. On 10/18/18 at 12:16 p.m. licensed practical nurse (LPN)-B confirmed R38 was routinely incontinent of bowel and bladder, needed to be repositioned checked/changed and R38 was at risk for pressure ulcers. On 10/19/18 at 10:46 a.m. the DON confirmed R38 required total assistance with ADL's and was routinely incontinent of bowel and bladder, needed to be checked/changed, turned and	2 900		

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2 900	Continued From page 47 reposition upon rising, before and after meals, at bedtime and with rounds during night shift. The DON verified R38 care plan, verified she was at risk for pressure ulcers and she would expect staff to turn and reposition R38 as per her schedule and to follow her care plan. On 10/18/18 at 2:51 p.m. via telephone interview, NA-E confirmed R38 required assistance of two staff with all cares and was incontinent of bowel and bladder and wore incontinent products. NA-E indicated she was not sure if R38 was at risk for pressure ulcers, but required staff to reposition her every two hours and checked/changed her. NA-E verified R38 had not been repositioned or checked/change before or after the supper meal and stated we tried to get in there right away. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as	2 965		11/28/18

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2 965	Continued From page 48 determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to address unplanned weight loss for 1 of 2 residents (R18) reviewed for nutrition. Findings include: R18's admission Minimum Data Set (MDS) dated 8/23/18, identified R18 had diagnoses which included; dementia, hemiplegia (weakness on one side of the body), and aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write). R18's MDS further identified R18's cognition was severely impaired, required extensive assistance with eating, and identified no rejection of care. R18's MDS also identified no dental issues, no swallowing issues, weight of 167 pounds, mechanically altered diet, and no or unknown weight loss of 5 % (percent) or more in the last month or 10% in the last 6 months. Review of R18's Care Area Assessments (CAA) dated 8/29/18, identified R18 was at risk for a nutritional problem and potential weight loss related to her cognitive impairment, her need for a pureed texture diet and on her dependence on staff to eat. R18's CAA indicated she rarely/never	2 965	Corrected	

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2 965	Continued From page 49 verbalized her needs and was dependent on staff for all activities of daily living (ADL) due to her cognitive impairment and deficits from her stroke years ago. The CAA further identified, R18 had limited understanding of others and would have physical behaviors during cares and verbal behaviors of yelling out during cares as she did not understand, and staff may have to re-approach. The CAA indicated these behaviors usually do not happen when staff assist her to eat. R18's CAA indicated her weight had been stable since admission and her meal intakes fluctuate, ranging from 25 to 100%. The CAA indicated R18's goal was to maintain her current weight and nutritional status with no significant weight loss. R18's care plan, last revised 10/19/18, identified R18 had the potential for decline in nutritional status related to dementia, aphasia, hemiplegia, dysarthria (condition in which the muscles you use for speech are weak or you have difficulty controlling them), need for pureed textures, and dependence on staff for eating/drinking. R18's care plan listed various interventions which included; occupational therapy or speech language pathology as ordered, regular diet with pureed textures and thin liquids, observe for signs and symptoms of dehydration, encourage fluid intake with meals and between, provide fluids per her preference, and provide water with meals and between. R18's Aide Care Guide Group B, dated 9/23/18, identified R18 required extensive assistance from one to two staff and was on a pureed texture diet. On 10/16/18, at 9:44 a.m. R18 was observed seated in a wheelchair in her room with eyes	2 965		

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2 965	Continued From page 50 opened. Family member (FM)-A stated R18 does not eat much at meals. FM-A indicated he visited daily and assisted R18 to eat some of her meals. On 10/17/18, at 5:20 p.m. R18 was seated in her reclined wheelchair at the dining room table. A dietary staff member approached R18 with two glasses of liquids, which were placed on the table in front of her. At 5:21 p.m. FM-A entered the dining room and approached the back of R18's wheelchair. FM-A used the controls on the wheelchair to assist R18 into an upright seated position at the table. FM-A then sat down in a chair beside R18 and talked. At 5:39 p.m. FM-A assisted R18 with sips of juice out of a standard cup. At 5:44 p.m. R18 and FM-A were both served a supper meal. FM-A assisted R18 with bites of pureed food and alternated with drinks of fluids. In between R18's bites of food FM-A would sit down and take bites of his own meal. At 5:55 p.m. he offered R18 a bite of food and she shouted "no". FM-A then tried a drink and R18 closed her lips tightly. FM-A then sat down and continued with his meal. At 6:00 p.m. FM-A finished his meal and asked staff seated at the table assisting another resident to eat, if they were going to help R18 eat. The unidentified staff member stated they would assist R18 when they were done assisting the resident they were already helping. FM-A then left the dining room. At 6:05 p.m. R18 continued to be seated in the wheelchair at the dining room table. R18 had begun holding her face with her left hand. At 6:10 p.m. R18 remained in the same position with face in her left hand as her supper meal of fruit, carrots, rice and chicken remained siting in front of her. At 6:12 p.m. the unidentified staff member approached R18 and encouraged her to eat some fruit. R18 did take a few more bites of fruit.	2 965		

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2 965	Continued From page 51 At 6:17 p.m. R18 refused to eat any more by stating "no" again, and staff assisted to wipe her face. R18 had consumed approximately 25% of the supper meal. On 10/18/18, at 11:57 a.m. R18 was seated in her wheelchair at the dining room table. Dietary staff brought R18 and FM-A lunch which consisted of mashed potatoes, meatballs and brussel sprouts. FM-A assisted R18 with four bites of the lunch meal when R18 yelled out "ow, ow". FM-A stopped attempting to assist R18 with her meal, turned her around in her wheelchair and pushed her wheelchair out of the dining room. At 12:40 p.m. R18's lunch remained at the dining room table. Review of R18's weight record from the electronic health record (EHR) from 8/17/18, to 10/12/18, revealed: -8/17/18, 164.6 -8/20/18, 167.4 -8/24/18, 166.1 -8/31/18, 166.4 -9/8/18, 167.1 -9/14/18, 167.0 -9/16/18, 167.0 -9/21/18, 165.7 -9/28/18,160.7	2 965		

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2 965	Continued From page 52 -10/5/18, 156.8 : R18's EHR showed a warning of a 5% weight change "[Comparison Weight 09/08/2018, 167.1 lbs [pounds], - [negative] 6.2%, -10.3 pounds]" -10/12/18, 155.9 : R18's EHR showed a warning of a 5% weight change "[Comparison Weight 09/14/2018, 167.0 lbs, - 6.6%, -11.1 pounds]" Review of R18's signed physician orders dated 9/5/18, indicated R18 had a pureed diet with thin liquids. However, after further review R18's orders had no orders to receive a dietary supplement. Review of R18's electronic record indicated in the last 30 days R18's meal intakes varied from 0-100%, she received total assistance for eating, and had accepted four bedtime snacks. Review of R18's Dietary Profile HDG [Health Dimensions Group], dated 8/22/18, indicated R18 was on a regular, pureed diet and regular liquids. The assessment indicated R18 was not on a fluid restriction, did not receive a nutrition supplement prior to admission, and did not receive a nutritional supplement currently. The assessment further indicated, R18 had regular portions, a fair appetite and drank four cups of fluids per day. Under the Likes and Dislikes text box only a dash was noted. R18 had good hearing and sight, was alert, did not have own teeth, did not indicate if a denture was worn, but had no chewing or swallowing problems. The assessment also indicated R18 used regular utensils, did not use adaptive equipment, and required total assistance. The assessment concluded with a comments text box which indicated R18 was hard to communicate other then yes or no	2 965		

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2 965	Continued From page 53 questions and a family member often sat with her. On 10/18/18, at 2:16 p.m. nursing assistant (NA)-J stated R18 was a total assist with all cares. She indicated R18's appetite depended on her mood and if staff get her started with the meal right away she does well. NA-J stated if R18 did well eating at breakfast, she would not each much at lunch. NA-J stated FM-A would sit with R18 often and would assist her to eat once in a while. She stated FM-A took R18 away from the dining room early today due to wanting to go for a car ride. NA-J stated if R18 did not eat well at a meal, then staff would try a pudding cup later after the meal. NA-J stated there was no place to document the pudding. She indicated R18 was weighed weekly by the NAs, and the NAs would document the weights in a binder and if the weight seemed off staff were to reweigh the resident. On 10/18/18, at 2:26 p.m. licensed practical nurse (LPN)-A stated R18 required total assist for all cares, including eating. LPN-A indicated R18's appetite had been okay and someday's she did not feel like eating. LPN-A stated if R18 did not eat well at a meal staff try to encourage her a little, and then let her rest. She stated the nurses should know about low meal intakes, but stated the NAs don't always tell us. LPN-A identified some residents on nutritional supplements, but confirmed R18 was not currently receiving a supplement. She stated R18 was weighed weekly on Fridays by the NAs, whom place the weight in a binder and the nurse would chart it in the EHR. LPN-A stated she did not review weights in the EHR and added it must be done by the upper management. She stated FM-A	2 965		

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2 965	Continued From page 54 assisted R18 to eat at times, but got frustrated easily and will leave, then staff would take over. Review of Weights B Group form, dated 8/27/18, through 10/14/18, indicated "Nurses-Please reweigh if wt [weight] is [up or down] 5 #[pounds] or more. Report to Dietary Manager if continues". R18's weight on 9/21/18, was 165.7 pounds and on 9/28/18, was 160.7 pounds, however no reweigh was identified. On 10/18/18, at 2:55 p.m. clinical manager (CM)-A indicated the nurses would chart the weights from the NA binder into the EHR and would look back to see if there were any concerns for changes and update the physician, CM-A, or the director of nursing (DON). CM-A stated the facility had a consultant dietician (CD) that came to the facility monthly. CM-A indicated the CD would be updated if the facility noted a significant weight loss or swallowing problem. CM-A reviewed R18's weights since admission and stated she had lost 9 pounds. CM-A reviewed R18's clinical record and confirmed R18 was not on a nutritional supplement, and R18's record lacked a dietician note or assessment. CM-A stated the facility would update the CD when a 5% weight change was noted and indicated the CD was last at the facility two weeks prior. On 10/19/18, at 9:16 a.m. during a phone interview CD-A stated she was the CD for the facility and her usual process would be to come to the facility monthly, and would be updated between visits via email or phone calls. CD-A stated she reviewed all residents annually, and anyone else the facility wanted her to assess, which included residents on tube feedings, those	2 965		

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FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

(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
2 965	Continued From page 55 with stage III pressure ulcers or higher, or significant weight loss of 5% or more in 30 days, or 10% in 180 days. CD-A stated she would get email updates from CM-A, DON, or the dietary manager (DM)-A. CD-A indicated she was unaware how the facility reviewed or tracked resident weights. CD-A stated the DM would complete the residents' quarterly assessments. CD-A stated R18's body max index (BMI) was over 24.9, so would be less concerned, but would expect an assessment to be completed to see what was going on with R18. On 10/19/18, at 9:38 a.m. NA-K stated R18's appetite was not good, and took a lot of encouragement to eat and added R18 never eats anything. NA-K indicated at times if staff started with something sweet her intake would be better. On 10/19/18, at 9:50 a.m. DM-A stated dietary staff charted the meal intakes, and nursing would chart the resident weights. DM-A indicated she did not review resident intakes or weights at this time and was something her and the DON were meeting on to discuss weights and nutritional supplements. DM-A indicated nursing staff would be reviewing residents for weight loss. DM-A stated R18's only dietary assessment was on admission and indicated the assessment was to gather information for R18's MDS. DM-A stated CM-A used to be the one to look at between MDS assessment nutritional needs, but CM-A was transitioning roles. DM-A stated she was not aware of R18's weight loss. On 10/19/18, at 11:27 a.m. the DON stated nurses were to review the resident weights when entering into the EHR and should be alerting CM-A, MDS coordinator, or the DON if a	2 965		

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2 965	Continued From page 56 significant weight loss was noted. DON stated a significant weight loss would be 5 pounds in a week. The DON indicated CM-A was in the process of reviewing R18's weights and were going to start some nutritional supplements. The DON stated R18's intakes have been up and down, and FM-A will sometimes just say that is enough and R18 will quit eating. The DON stated staff should have alerted CM-A on R18's weight loss after the 9/21/18, to 9/28/18, weight loss, so CM-A could have alerted the CD. The DON stated her expectation for staff was to follow the directions on the Weights B Group form which instructed the nurse to reweigh if a five pound weight loss and report to the DM. Review of the facility policy titled Nutrition, dated 4/1/08, indicated the facility maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this was not possible. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section K: Swallowing/Nutritional Status to be completed with an intent to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. Under K0300: Weight Loss Planning for Care: "-Weight loss may be an important indicator of a change in the resident' s health status or environment. -If significant weight loss is noted, the interdisciplinary team should review for possible	2 965		

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2 965	Continued From page 57 causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status. - Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment." SUGGESTED METHOD OF CORRECTION: The Dietician could review/revise facility policies regarding residents at nutritional risk, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and sanitary kitchen environment to prevent foodborne illness. Furthermore, the facility failed to prepare food in a sanitary manner in 1 of 1 kitchens observed when staff did not utilize hairnets when walking through the preparation area. This had the potential to affect 39 of the 41 residents that received food from the kitchen. Findings include:	21015	Corrected	11/28/18

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21015	Continued From page 58 On 10/15/18 at 7:01 a.m. during an initial tour of the facility kitchen area with cook (C)-A the following concerns were identified: - the coffee maker in the kitchen area, had encrusted hard water lime scale build up with small flakes under the three coffee dispensers. At 8:09 a.m. during observations of taking temperatures of food items. A white fan was blowing above the dishwasher and above the clean dish area. The fan had black dust particles on the entire front of it with pieces of long lint/dirt blowing away from the fan and into the air. -at 8:34 a.m. the little sink next to the juice machine in the dining room area of the facility had encrusted hard water lime scale build up with flakes around the faucet, the handles of the sink, and around the entire outer edge of the sink. On 10/19/18 at 9:15 a.m. during a tour of the kitchen with the DM-A the following concerns were identified: - the little sink next to the juice machine in the dining room area of the facility had encrusted hard water lime scale build up with flakes around the faucet, the handles of the sink, and around the entire outer edge of the sink. The DM-A indicated all staff use the sink to wash their hands and was not sure who was responsible for cleaning and de-liming the sink. - three compartment sink in the kitchen are had encrusted hard water lime scale build up with flakes around the faucet, the handles of the sink, the sink compartments and around the entire outer edge of the sink. - the ice machine located in the kitchen area had encrusted hard water lime scale build up on the upper lip on the outside of the ice machine lid.	21015		

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21015	Continued From page 59 - the air conditioner in the window near the prepping area was blowing and had black dust particles on the entire front of it with pieces of long lint/dirt blowing away from the air conditioner and into the air. - the coffee maker in the kitchen area, had encrusted hard water lime scale build up with small flakes under the three coffee dispensers. The DM-A confirmed the above findings and coffee machine was to be cleaned weekly, the sinks should be cleaned daily and the fans cleaned weekly. The DM also indicated they needed to do a better job with de-liming the sinks and ice machine. On 10/19/18 at 10:01 a.m. the maintenance supervisor (MS) confirmed the kitchen and housekeeping staff were responsible for de-liming the the sinks in the dining room and kitchen area. The MS indicated he did not have any cleaning logs for these areas. Review of facility policy titled, Cleaning and Sanitation of Dining and Food Services undated, indicated the food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. 10/19/18 requested policy in regards to labeling and dating food items, one was not provided. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for	21015		

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21015	Continued From page 60 all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21015		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide arrangements for dental care for 1 of 1 residents (R28) reviewed for dental services. Findings include: R28's quarterly Minimum Data Set (MDS) dated 9/19/18, identified R28 was cognitively intact and had diagnoses which included paraplegia (impairment in motor or sensory function of the lower extremities), muscle weakness and limitations of activities due to disability. The MDS identified R28 required assistance with personal	21325	Corrected	11/28/18

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21325	Continued From page 61 hygiene. R28's MDS further identified no dental concerns. R28's care plan revised 9/25/18, indicated R28 had an activities of daily living (ADL) self care performance deficit related to her impaired balance and limited mobility. R28's care plan further indicated she had her own teeth and was independent with oral cares after set up. On 10/15/18, at 9:19 a.m. R28 indicated she needed to see a dentist. R28 indicated they had spoken to her about seeing a dentist at the facility, and once notified her while she was in the bathroom the dentist had come to the facility, but had not been seen by the dentist. R28's admission assessment dated 3/26/18, identified R28 had her own teeth. Review of R28's care conference notes identified the following: -4/10/18, concerns: teeth/dental- due for cleaning, has partial plate, does not always wear. Form indicated R28 attended the meeting. -6/26/18, concerns: teeth/dental-blank, form indicated R28 attended the meeting. No reference to dental appointment included. -9/25/18, documentation indicated R28 was invited to meeting, but refused. No reference to dental appointment included. There was no indication R28 had seen a dentist, even though the 4/10/18 note identified R28 was due for a cleaning.	21325		

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21325	Continued From page 62 On 10/18/18, at 9:53 a.m. licensed practical nurse (LPN)-B indicated R28 was cognitively intact and could inform you if she wanted something. LPN-B indicated R28 had never asked her about dental appointments. On 10/19/18, at 8:57 a.m. R28 indicated when she arrived she informed the facility staff she was due for a dental cleaning. R28 stated she would still like to see a dentist, and no one had spoken to her about setting up a dental appointment or transportation. On 10/19/18, at 9:56 a.m. clinical manager (CM)-A indicated she was not aware R28 requested to see a dentist. CM-A confirmed dental exams were discussed at resident care conferences. CM-A indicated the usual facility practice was for the facility to set up dental appointments and transportation. CM-A indicated she would ask residents or responsible parties if a dental exam was needed or wanted and try to arrange the appointment and transportation if needed. On 10/19/18, at 10:42 a.m. director of nursing (DON) indicated the facility's usual practice for dental exams was the residents were asked on admission if they wanted to see a dentist, or had any concerns. DON indicated they would then assist the resident to schedule the exam if they had a regular dentist, or could be screened by Apple Tree Dental at the facility. DON indicated Apple Tree Dental came into the facility routinely and would screen residents. DON indicated the floor staff could assist in scheduling exams and transportation, or they could inform herself or CM-A who could assist in arranging the dental appointments and transportation. DON indicated	21325		

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21325	Continued From page 63 her expectations would be for a resident to to added to the Apple Tree Dental list or assisted in a dental appointment if requested or needed. On 10/19/18, at 12:36 p.m. CM-A indicated she had just followed up with R28 regarding a dental exam. CM-A confirmed R28 still wanted a dental appointment. CM-A indicated R28 informed her she would arrange her appointment herself after she felt better, and asked the facility to arrange for transportation. The facility policy titled Dental Services (General) -HDGR (Health Dimensions Group) revised 9/22/17, identified the community (facility) would provide or obtain routine and emergency dental services to meet the needs of each resident. The policy further indicated the community would assist the resident in making appointments by arranging transportation to and from the dentist's office. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		11/28/18

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21375	Continued From page 64 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include timely surveillance data, including viral infections and illnesses not treated with antibiotics to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 41 residents who currently resided in the facility. Findings include: INFECTION CONTROL PROGRAM Review of the facility forms titled Frazee Care Community Infection Control Log from January 2018, to October 2018 revealed the following: The forms included the month and year. They also included columns of date, name of resident, room number, signs and symptoms, X-Ray results, UA (urine analysis) results, medications, precautions, present on admit, acquired in house and date resolved. All areas were completed on forms for the entries listed below. -January 2018, one resident was identified with wheezing, rhonchi, diminished breath sounds and fever, treatment with Augmentin. No further illnesses or viral infections were listed. -February 2018, four residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed.	21375	Corrected	

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21375	Continued From page 65 -March 2018, two residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -April 2018, four residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -May 2018, eight residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -June 2018, fourteen residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -July 2018, ten residents were identified with various symptoms. All were treated with antibiotics. First page identified eight residents in sequence from 7/3/18, to 7/20/18. Second page included two residents identified on 7/10/18, then 7/15/18. No further illnesses or viral infections were listed. -August 2018, five residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -September 2018, fourteen residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -October 2018, four residents were identified with	21375		

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21375	Continued From page 66 various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. On 10/19/18, at 11:41 a.m. director of nursing (DON) indicated she completed the infection control surveillance forms. DON confirmed the facility only tracked those residents who received antibiotic treatment and did not complete tracking on weekends. DON indicated she read resident progress notes daily when she was present and checked for any new infections and orders. DON indicated she reviewed the weekend notes for infections on Mondays. The facility policy titled Infection Prevention and Control (General) revised 11/2016, specified a system was in place that prevents, identifies, reports, investigates, and controls infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing service under a contractual arrangement and following accepted national standards. The policy further identified a system was in place for surveillance designed to identify possible communicable disease or infections before they could be spread to other persons in the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		

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21880	Continued From page 67	21880		
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 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	21880		11/28/18

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21880	Continued From page 68 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 observation, interview and document review, the facility failed to provide appropriately fitting incontinence products to maintain personal dignity for 1 of 1 resident (R27) observed for incontinence care. Findings include: R27's significant change Minimum Data Set (MDS) assessment, dated 9/14/18, identified diagnoses which included previous surgical removal of part of the digestive tract, morbid obesity and edema (swelling). The MDS also indicated R27 was cognitively intact and required limited assistance of one staff with bed mobility, transfers, walking in his room and extensive assistance of one staff with toileting. The MDS further identified R27 was frequently incontinent of bladder and occasionally incontinent of bowel and had no toileting program. R27's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/20/18, indicated R27 was incontinent of bladder and bowel and attempted to manage this independently in preparation for discharge, however, staff continued to assist him with incontinence cares and changing incontinence products due to obesity. R27's CAA further indicated R27 received diuretic (promotes the	21880	Corrected	

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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
21880	Continued From page 69	21880		

increased production of urine) medication for edema which may have contributed to R27's urinary urgency and incontinence. The CAA revealed R27 felt the urge to urinate but stated could not make it to the toilet in time.

R27's care plan, revised on 9/7/18, identified R27 had urinary retention, chronic urethral stricture (narrowing of the tube that carries urine out of the body) and previously had a urinary catheter. The care plan also indicated R27 was incontinent of bladder at all times and of bowel occasionally. The care plan further indicated R27 was independent with toileting on the commode and required extensive assist of 1 staff to complete incontinence and perineal cares. The care plan directed staff to observe for signs and symptoms of discomfort on urination and frequency, observe/record/report to physician signs and symptoms of urinary tract infection and provide prompt incontinence cares.

R27's nursing assistant guide plan undated, indicated R27 was incontinent of bladder and bowel, wore a brief, was independent with toileting and required assistance with washing up after incontinence episodes.

On 10/15/18, at 7:32 a.m. R27's call light was observed to be on and R27 was seated in a chair in his room with shirt on, no bottoms present, and incontinent brief was off due to incontinent episode. Strong odor of urine emanated from the room and was noted in the hallway as well. R27 stated he needed assistance from staff and was waiting for staff to assist with incontinence cares.
-At 7:36 a.m. licensed practical nurse (LPN)-B exited R27's room and call light was turned off.
-At 7:45 a.m., nursing assistant (NA)-B was in

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	00730	A. BUILDING: _____ B. WING _____	C 10/19/2018

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21880	Continued From page 70 R27's room wiping up urine and a couple of drops of stool from R27's floor while wearing gloves. NA-B removed soiled gloves, washed hands, applied clean gloves and assisted with perineal cares. NA-B informed R27 she would have housekeeping staff come in and clean the floor. -At 7:53 a.m. R27 stood, holding onto a walker while NA-B attempted to apply a pull-up type incontinence product . The pull-up product could only be pulled up halfway leaving R27's buttocks and part of his scrotum exposed. R27 was noted to have a large cyst to the upper inner left thigh area which was visible from both the front and back. NA-B removed old gloves and completed hand hygiene. -At 7:55 a.m. R27 independently walked using a walker to a chair by the head of the bed and seated himself on the chair. An incontinence pad was present on seat of the chair. NA-B folded an incontinence pad in half and placed it on the floor in front of R27's feet. NA-B then proceeded to take the bucket from a commode and place on top of the pad right in front of R27's feet on the floor. R27's commode was observed to be placed across the room, approximately 7 feet from R27's chair. On 10/16/18, at 2:28 p.m. R27 stated the pull-ups he wore leaked because they were too small for him. R27 stated since the urinary catheter was removed in September 2018 he had experienced urinary incontinence. R27 indicated he was independent with walking in his room using a walker but did require assistance with cleansing and applying incontinence pull-ups after incontinence episodes. R27 further stated the incontinence pad on the floor and the bucket from the commode were placed in front of him	21880		

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21880	Continued From page 71 when he sat in the chair to catch the urine that leaked from the improperly-fitting pull-up. R27 stated if the bucket was in the right spot it would catch the urine, however, sometimes it would not catch the leaking urine and in those instances the urine would then land on the floor. R27 stated having the bucket and pad underneath in this manner didn't make him feel good and stated "I shouldn't have to do this". R27 further explained he had requested pull-ups sized 3 XL be ordered for him when the urinary catheter had been removed in September. R27 also stated he had a large cyst to his left thigh that made it difficult to find properly fitting incontinence products. On 10/17/18, at 2:22 p.m. R27 was seated in the chair by his bed with an incontinence pad on the floor in front of him and a bucket from his commode on top of the pad. R27 had a hospital gown covering his lap. R27 stated he did not typically wear pants and preferred to wear shorts. R27 explained he had a black pair of shorts in the closet but did not wear them due to the leaking urine concern. R27 stated he had been informed that day by facility staff that 3 XL sized pull-ups would be coming in tomorrow. R27 stated he didn't understand why it took so long to get the right-sized incontinence products in. On 10/17/18, at 4:59 p.m. R27 was seated in the chair by his bed watching the news on TV with an incontinence pad on the floor in front of him and a bucket from a commode on top of the pad. R27 had a hospital gown covering his lap. On 10/17/18, at 7:26 p.m. NA-D indicated R27 could not reach behind his back and needed assistance from nursing staff to complete incontinence cares. NA-D further expressed R27	21880		

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21880	Continued From page 72 could not control his urine stream and was not aware when he was incontinent. NA-D stated the bucket was placed in front of R27, in between his legs, to catch the leaking urine. NA-D further stated the pull-ups used for R27 were too small and did not contain the leaking urine. On 10/18/18, at 10:17 a.m. NA-B stated R27 was incontinent of urine at all times and required assistance from staff with perineal cares after incontinent episodes. NA-B stated the pull-ups used to manage R27's incontinence were too small and leaked urine. NA-B indicated the bucket from a commode was placed in front of R27 on the floor when he was seated in the chair to catch the leaking urine that dripped from R27's pull-up. NA-B further stated the toileting plan for R27 used to be to offer toileting every two hours however R27 would say he didn't have to go to the bathroom and as a result they no longer offered toileting every 2 hours. On 10/18/18, at 11:38 a.m. the MDS coordinator (MDSC) indicated R27 was admitted to the facility with a urinary catheter in place. MDSC indicated R27 elected to have the urinary catheter removed and tried to manage the urinary incontinence instead. MDSC indicated she was aware of the bucket from the commode being placed in front of R27 when he was seated in the chair. MDSC stated there was no specific toileting plan for R27 due to the fact he was alert and oriented and could use the call light. On 10/19/18, at 9:20 a.m. office and medical records manager (OMRM) stated she ordered supplies for R27 and all residents. OMRM indicated Medline was the facility's usual supplier for incontinence products. OMRM stated	21880		

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21880	Continued From page 73 Medline did not have R27's size and OMRM researched products from Tenna. OMRM stated size 3 XL disposable briefs were ordered, trialed and R27 did not want the briefs. OMRM revealed everything that had been ordered thus far had not worked for R27. OMRM stated she continued to research other options and indicated there had to be something out there for R27. OMRM verified there was no current order placed for 3 XL pull-ups for R27. On 10/19/18, at 9:38 a.m. director of nurses (DON) stated R27's urinary incontinence developed after the urinary catheter was removed. After DON reviewed R27's care plan, DON stated R27 required assistance with urinary incontinence and R27 dribbled constantly. DON stated she was not aware the pull-up brief currently being utilized for R27 only covered half of R27's bottom. DON stated attempts to order different sized briefs had not met R27's expectations. DON stated R27 didn't want to use the briefs as they did not cover his cyst and preferred the pull ups. DON expressed other interventions could have been tried to manage R27's urinary incontinence such as: moving the commode closer, setting up his room better, increasing assistance and trying new products. The facility policy titled, Dignity Quality of Life, dated April 1st, 2008, stated in full recognition of his or her individuality, the facility promoted care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to	21880		

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21880	Continued From page 74 ensure resident incontinence is managed in a dignified manor. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/16/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Frazee Care Center 01 Main Building was found not in compliance with The requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities code "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2018

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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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/16/2018**

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as one building: Frazee Care Center was constructed at three different times. The original building was constructed in 1971, is 1-story without a basement and was determined to be of a Type II(111) construction. In 1979 the north 200 wing addition was built. It is 1-story without a basement, was determined to be of a Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the 1979 building in 1993 include an activities addition to the west and the business/ main entrance addition to the east. These areas were determined to be Type V (111) construction and the business / main entrance addition is separated from the apartment building with a 2-hour fire barrier.	K 000		

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K 000	Continued From page 2 The facility is completely sprinkler protected and has a fire alarm system with smoke detection throughout the corridor system and in the common spaces that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		11/28/18

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to construct 4 hazardous storage rooms in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for all of the 60 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2018 observations revealed the following rooms were converted to combustible storage over 50 sq. ft. and did not have self closing doors. Rooms, 100, 101, 404 and a storage room across from resident room 207. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 321	All equipment in Rooms 100 and 101 have been moved out so they are no longer storage rooms. Storage was moved to 402 and 404. Walls were checked and completely sealed. Self closing devices will be added to the three storage room doors. Routine audits will be done to assure empty resident rooms do not become storage rooms. Audits will be reviewed annually in QAPI meeting by the Maintenance Director.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324		11/28/18

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K 324	Continued From page 4 Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to install the protection devices of the cooking equipment as stated in the Life Safety Code (NFPA 101) 2012 edition section 9.2.3 & NFPA 96 section 10.5.1. This deficient practice could allow for the spread of fire if staff could not reach the device, affecting an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2018 observations revealed the kitchen hood pull station was located less than 10 feet from the appliance.	K 324	The kitchen hood pull station was moved by Summit Companies to more than 10 feet from the appliance.	

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/16/2018**

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K 324	Continued From page 5 This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.5 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 14.3.1. This deficient condition could delay alarm notification in case of a fire and affect all 60 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2018 documentation review revealed the smoke detector near the nurses office in the 200 wing and a smoke detector in the corridor near room 119 was shown as not tested on the sensitivity report. This deficient condition was confirmed by the	K 345	Detectors near the nurse's office in the 200 wing and the detector near room 119 will be tested by Summit Companies. The results of the sensitivity testing will be reviewed annually in QAPI meeting by the Maintenance Director.	11/28/18

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K 345	Continued From page 6 facility Administrator and the Director of Maintenance.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 The standard for testing and maintenance of sprinkler systems, section 14.2.1. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all 60 of the residents and an undetermined amount of staff and visitors. Findings include:	K 353	The 5 year obstruction inspection will be completed by Summit Companies. The results of the obstruction inspections will be reviewed annually in QAPI meeting by the Maintenance Director.	11/28/18

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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 353	Continued From page 7 On the facility tour between 8:00 am to 12:00 pm on 10/19/2018 documentation review revealed there was no record of a 5 year obstruction inspection. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 353		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 7, 2018

Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, MN 56544

Re: State Nursing Home Licensing Orders - Project Number S5299032, H5299010, H5299011, and H5299012

Dear Administrator:

The above facility was surveyed on October 15, 2018 through October 19, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5299010. In addition, at the time of the October 19, 2018 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5299011, and H5299012 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on , during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted October 15-19, 2018, and complaint investigations were also completed at the time of the standard survey. Investigations of H5299010, H5299011, and H5299012, were completed. The complaint that was found to be substantiated along with the related deficiency is as follows: H5299010. Deficiency issued at F Tag # 686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		11/28/18

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

Electronically Signed | 11/14/2018

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F 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 550	Submission of this Response and Plan of	

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F 550	Continued From page 2 review, the facility failed to provide appropriately fitting incontinence products to maintain personal dignity for 1 of 1 resident (R27) observed for incontinence care. Findings include: R27's significant change Minimum Data Set (MDS) assessment, dated 9/14/18, identified diagnoses which included previous surgical removal of part of the digestive tract, morbid obesity and edema (swelling). The MDS also indicated R27 was cognitively intact and required limited assistance of one staff with bed mobility, transfers, walking in his room and extensive assistance of one staff with toileting. The MDS further identified R27 was frequently incontinent of bladder and occasionally incontinent of bowel and had no toileting program. R27's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/20/18, indicated R27 was incontinent of bladder and bowel and attempted to manage this independently in preparation for discharge, however, staff continued to assist him with incontinence cares and changing incontinence products due to obesity. R27's CAA further indicated R27 received diuretic (promotes the increased production of urine) medication for edema which may have contributed to R27's urinary urgency and incontinence. The CAA revealed R27 felt the urge to urinate but stated could not make it to the toilet in time. R27's care plan, revised on 9/7/18, identified R27 had urinary retention, chronic urethral stricture (narrowing of the tube that carries urine out of the	F 550	correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. o R27 has had a comprehensive bowel and bladder assessment and plan of care updated to reflect care of incontinence in accordance with his preferences. o Other residents with incontinence were reviewed to ensure proper fit of incontinence product o Education provided to nursing department on the need for properly fitting incontinence products to maintain resident dignity o Audits of properly fitting incontinence products will be done on 3 residents two	

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F 550	Continued From page 3 body) and previously had a urinary catheter. The care plan also indicated R27 was incontinent of bladder at all times and of bowel occasionally. The care plan further indicated R27 was independent with toileting on the commode and required extensive assist of 1 staff to complete incontinence and perineal cares. The care plan directed staff to observe for signs and symptoms of discomfort on urination and frequency, observe/record/report to physician signs and symptoms of urinary tract infection and provide prompt incontinence cares. R27's nursing assistant guide plan undated, indicated R27 was incontinent of bladder and bowel, wore a brief, was independent with toileting and required assistance with washing up after incontinence episodes. On 10/15/18, at 7:32 a.m. R27's call light was observed to be on and R27 was seated in a chair in his room with shirt on, no bottoms present, and incontinent brief was off due to incontinent episode. Strong odor of urine emanated from the room and was noted in the hallway as well. R27 stated he needed assistance from staff and was waiting for staff to assist with incontinence cares. -At 7:36 a.m. licensed practical nurse (LPN)-B exited R27's room and call light was turned off. -At 7:45 a.m., nursing assistant (NA)-B was in R27's room wiping up urine and a couple of drops of stool from R27's floor while wearing gloves. NA-B removed soiled gloves, washed hands, applied clean gloves and assisted with perineal cares. NA-B informed R27 she would have housekeeping staff come in and clean the floor. -At 7:53 a.m. R27 stood, holding onto a walker	F 550	times weekly for four weeks, then 1 time per week for a month, then monthly for 2 months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed o Compliance date 11/28/2018	

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F 550	Continued From page 4 while NA-B attempted to apply a pull-up type incontinence product . The pull-up product could only be pulled up halfway leaving R27's buttocks and part of his scrotum exposed. R27 was noted to have a large cyst to the upper inner left thigh area which was visible from both the front and back. NA-B removed old gloves and completed hand hygiene. -At 7:55 a.m. R27 independently walked using a walker to a chair by the head of the bed and seated himself on the chair. An incontinence pad was present on seat of the chair. NA-B folded an incontinence pad in half and placed it on the floor in front of R27's feet. NA-B then proceeded to take the bucket from a commode and place on top of the pad right in front of R27's feet on the floor. R27's commode was observed to be placed across the room, approximately 7 feet from R27's chair. On 10/16/18, at 2:28 p.m. R27 stated the pull-ups he wore leaked because they were too small for him. R27 stated since the urinary catheter was removed in September 2018 he had experienced urinary incontinence. R27 indicated he was independent with walking in his room using a walker but did require assistance with cleansing and applying incontinence pull-ups after incontinence episodes. R27 further stated the incontinence pad on the floor and the bucket from the commode were placed in front of him when he sat in the chair to catch the urine that leaked from the improperly-fitting pull-up. R27 stated if the bucket was in the right spot it would catch the urine, however, sometimes it would not catch the leaking urine and in those instances the urine would then land on the floor. R27 stated having the bucket and pad underneath in this	F 550		

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F 550	Continued From page 5	F 550		

manner didn't make him feel good and stated "I shouldn't have to do this". R27 further explained he had requested pull-ups sized 3 XL be ordered for him when the urinary catheter had been removed in September. R27 also stated he had a large cyst to his left thigh that made it difficult to find properly fitting incontinence products.

On 10/17/18, at 2:22 p.m. R27 was seated in the chair by his bed with an incontinence pad on the floor in front of him and a bucket from his commode on top of the pad. R27 had a hospital gown covering his lap. R27 stated he did not typically wear pants and preferred to wear shorts. R27 explained he had a black pair of shorts in the closet but did not wear them due to the leaking urine concern. R27 stated he had been informed that day by facility staff that 3 XL sized pull-ups would be coming in tomorrow. R27 stated he didn't understand why it took so long to get the right-sized incontinence products in.

On 10/17/18, at 4:59 p.m. R27 was seated in the chair by his bed watching the news on TV with an incontinence pad on the floor in front of him and a bucket from a commode on top of the pad. R27 had a hospital gown covering his lap.

On 10/17/18, at 7:26 p.m. NA-D indicated R27 could not reach behind his back and needed assistance from nursing staff to complete incontinence cares. NA-D further expressed R27 could not control his urine stream and was not aware when he was incontinent. NA-D stated the bucket was placed in front of R27, in between his legs, to catch the leaking urine. NA-D further stated the pull-ups used for R27 were too small and did not contain the leaking urine.

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F 550	Continued From page 6 On 10/18/18, at 10:17 a.m. NA-B stated R27 was incontinent of urine at all times and required assistance from staff with perineal cares after incontinent episodes. NA-B stated the pull-ups used to manage R27's incontinence were too small and leaked urine. NA-B indicated the bucket from a commode was placed in front of R27 on the floor when he was seated in the chair to catch the leaking urine that dripped from R27's pull-up. NA-B further stated the toileting plan for R27 used to be to offer toileting every two hours however R27 would say he didn't have to go to the bathroom and as a result they no longer offered toileting every 2 hours. On 10/18/18, at 11:38 a.m. the MDS coordinator (MDSC) indicated R27 was admitted to the facility with a urinary catheter in place. MDSC indicated R27 elected to have the urinary catheter removed and tried to manage the urinary incontinence instead. MDSC indicated she was aware of the bucket from the commode being placed in front of R27 when he was seated in the chair. MDSC stated there was no specific toileting plan for R27 due to the fact he was alert and oriented and could use the call light. On 10/19/18, at 9:20 a.m. office and medical records manager (OMRM) stated she ordered supplies for R27 and all residents. OMRM indicated Medline was the facility's usual supplier for incontinence products. OMRM stated Medline did not have R27's size and OMRM researched products from Tenna. OMRM stated size 3 XL disposable briefs were ordered, trialed and R27 did not want the briefs. OMRM revealed everything that had been ordered thus	F 550		

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F 550	Continued From page 7 far had not worked for R27. OMRM stated she continued to research other options and indicated there had to be something out there for R27. OMRM verified there was no current order placed for 3 XL pull-ups for R27. On 10/19/18, at 9:38 a.m. director of nurses (DON) stated R27's urinary incontinence developed after the urinary catheter was removed. After DON reviewed R27's care plan, DON stated R27 required assistance with urinary incontinence and R27 dribbled constantly. DON stated she was not aware the pull-up brief currently being utilized for R27 only covered half of R27's bottom. DON stated attempts to order different sized briefs had not met R27's expectations. DON stated R27 didn't want to use the briefs as they did not cover his cyst and preferred the pull ups. DON expressed other interventions could have been tried to manage R27's urinary incontinence such as: moving the commode closer, setting up his room better, increasing assistance and trying new products. The facility policy titled, Dignity Quality of Life, dated April 1st, 2008, stated in full recognition of his or her individuality, the facility promoted care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect.	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group,	F 565		11/28/18

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F 565	Continued From page 8 to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to take prompt action to resolve grievances from resident council for 5 of 11 residents (R9, R31, R33, R39, R40) with concerns of missing clothing. Findings include:	F 565	o R31 and R39 no longer reside at the community. o R9, R33, and R40 have been interviewed for grievance on missing clothing and resolutions determined o All interviewable residents interviewed for missing clothing and	

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F 565	Continued From page 9 On 10/16/18, at 1:30 p.m., a resident council meeting was held and the following residents attended the meeting: R3, R4, R8, R9, R11, R13, R31, R33, R36, R39 and R40. During the meeting the following concerns were voiced: Residents voiced concerns about clothing being lost or delivered to the wrong residents. The residents indicated there was a concern with clothing not being labeled. R33 stated staff were supposed to label a bag of clothing for her, it wasn't completed and she noticed one day another resident was wearing one of R33's shirts. R31 and R33 revealed they were informed by staff to mark their clothing themselves and were given a marker to do so. R31 indicated he was missing shirts, t-shirts, stockings for four weeks and R31 had received shirts that didn't belong to him. R31 stated he had reported this to laundry staff several times. R33 stated she was sure she was missing clothing but wasn't sure what at this time. R33 revealed a pair of pants she owned came back to her from the laundry with a huge hole in them. R33 stated this was reported to laundry staff and the administrator. R33 verbalized the pants had never been replaced. R9 stated she was missing two pairs of slacks, one bra and a pair of slippers. R9 stated it had been reported to several staff and at resident council meetings. On 4/27/18, a grievance form was completed regarding the missing bra and pair of slippers. At the bottom of the form a staff member indicated several student nurses had	F 565	follow up completed as indicated. Additionally, Resident council minutes for last 3 months reviewed and grievances addressed if indicated. o A representative for the non-interviewable residents will be interviewed for missing clothing and follow up as indicated o All reports of missing clothing/grievances brought up during resident council will be treated and followed up on using the established grievance process, which includes communication back to the resident regarding any concerns. o Education provided to IDT on expected resident council follow up and grievance process o Audit resident council grievances by interviewing 5 residents two times per week for four weeks and then once per week for a month and then monthly for two months o E.D. will review all grievances and assure follow-up within timeline per policy o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed o Compliance date. 11/28/2018	

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 565	Continued From page 10	F 565		

worked with the resident and the clothes never made it to laundry. The staff member further indicated he or she believed the student nurses had thrown the clothing in the wrong bin. Nothing was documented on the grievance resolution page of the form.

R40 indicated she was missing 36 pairs of underwear and had reported it to "everyone."

Review of Resident Council Minutes from 5/23/18 through 9/28/18 revealed the following:

On 5/23/18, one resident reported missing a pair of socks.

On 6/29/18, no reports of missing laundry.

On 7/30/18, residents questioned why their clothing was missing all of the time. No new missing clothing items reported at this meeting.

On 8/24/18, one resident reported missing a jacket and another resident reported missing two pairs of jeans, two shirts and some underwear.

On 9/28/18, residents again questioned why their clothing was frequently missing. Residents indicated they had received many clothing items that don't belong to them. Residents further stated if they don't label their own clothing it doesn't get done and clothing items become lost after one trip to the laundry room. One nursing assistant (NA) attended this meeting and revealed NA always had to dig through piles of laundry in the laundry room to search for resident clothing. NA further indicated these searches for resident laundry occur almost daily.

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F 565	Continued From page 11 On 10/17/18, at 7:26 p.m., nursing assistant (NA-D) stated when a resident reported missing laundry staff completed a missing laundry form and placed it in the out basket. NA-D further indicated staff were expected to conduct an immediate search of the laundry room to search for the missing item as well. NA-D stated laundry staff are responsible for marking clothing items for all residents. NA-D revealed laundry being delivered to the wrong resident happened frequently and on an almost daily basis. On 10/18/18, at 9:53 a.m., housekeeper (H)-C stated when new residents are admitted nursing staff bagged the clothing belonging to the new resident and delivered the bag to the laundry room. H-C indicated the nursing staff left a note on the bag that identified who the new resident was. H-C further stated laundry staff are responsible for marking the clothing for each resident. When clothing was reported missing, H-C revealed staff were to complete a missing laundry slip if the clothing cannot be located once a thorough search had been completed. H-C further revealed the missing laundry slips are stored at each nursing station and in the laundry room. H-C indicated she attempted to follow-up with residents herself on the status of their missing clothing. On 10/18/18, at 10:40 a.m., social services assistant (SSA) stated September was the first resident council meeting he had attended. SSA verified residents who attended the September meeting had expressed concerns about missing clothing. SSA further indicated there was a systems concern, trends were noted with missing	F 565		

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F 565	Continued From page 12 clothing and there were intentions to have a meeting to review the process with SSA, Administrator and H-C. SSA verified the meeting had not yet occurred. On 10/19/18, at 9:57 a.m., director of nurses (DON) stated staff are expected to complete a missing laundry form, look for the missing clothing on the unit and in the laundry room. DON revealed laundry staff reported at the daily stand up meetings when a resident was missing clothing. DON indicated the daily meetings are attended by DON and Administrator and they determined if the missing item needed to be replaced or not. DON further stated a grievance form should be completed as well. DON expressed there needed to be improvement in the process for keeping track of resident clothing. Review of facility policy titled, Grievance Process revised on 3/2018, indicated the facility would make prompt efforts to resolve grievances. The policy further indicated investigation and resolution of the grievance would be completed as soon as possible and no later than five working days after the grievance was submitted.	F 565		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		11/28/18

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F 604	Continued From page 13 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R5) was free from the use of physical restraints. Findings include: R5's face sheet dated 10/19/18, indicated R5 had diagnoses which included vascular dementia with behavioral disturbance, anxiety disorder and cerebrovascular disease. R5's quarterly Minimum Data Set (MDS) dated 7/18/18, indicated R5 had severe cognitive impairment and required extensive assistance of	F 604	o R5 has had restraint removed every two hours and with meals per plan of care o No other residents are identified as using restraints o Education provided on use of restraints to include releasing restraint every two hours and during meal times as well as the use of wheelchair brakes as a restraint o Audit of restraint use to be done two times per week for four weeks and then once per week for one month and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for	

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F 604	Continued From page 14 two staff for bed mobility. The MDS indicated R5 also required extensive assistance of one staff for transfers, dressing, eating, toileting, personal hygiene, and walking. The MDS further indicated R5 utilized a chair restraint daily to prevent rising and personal alarms used while in bed and in the wheelchair. R5's Physical Restraint Care Area Assessment (CAA) dated 1/30/18, indicated R5 utilized a lap tray on her wheel chair to prevent rising and self transfer attempts as R5 has history of frequent falls due to self transferring. R5 had a diagnosis of dementia and displayed severe cognitive impairment with orientation, short term and long term memory issues. R5 also had very poor safety awareness and decision making which had contributed to her past falls and the lap tray. R5's care plan revised on 2/8/18, indicated R5 used an external device for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility, physical aggression related to cognitive impairment and motor agitation. The care plan listed various interventions which included: lap tray restraint device every two hours while in wheel chair. Stand, reposition, walk in hallways and reapply. Off during meals. The care plan also indicated physician ordered restraint of lap tray, release and reposition every two hours and off at meals. The care plan further indicated to try alternative methods before using physical restraints with R5. If restraint still required, place in restraint-reduction program. R5's Aide Guide Group A undated, indicated R5 required extensive assistance of one staff for	F 604	3 months to review and follow-up as needed o Compliance date. 11/28/2018	

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F 604	Continued From page 15	F 604		

eating and directed staff to release lap tray every two hours, stand up/walk, reposition, replace device and off at meals. Miscellaneous directions included the following in bold type: lap tray at all times, release and off load every two hours and off at meals.

During observations of the supper meal in the main dining room on 10/17/18 at 5:30 p.m. R5 was seated in her wheelchair with a black lap tray attached to the wheelchair arms. R5 was attempting to pedal herself into the kitchen area with her feet.
- at 5:55 p.m. dietary staff brought R5 a plate of food which consisted of pureed mixed fruit, carrots, pineapple chicken and rice. R5 had a glass of thickened water, milk and cranberry juice sitting on the table. R5 continued to have the black lap tray attached to her wheelchair while she tried to propel herself backwards into the kitchen area.
-at 6:02 p.m. nursing assistant (NA)-E assisted R5 back to the dining room table via wheelchair with attached lap tray and encouraged R5 to begin eating her food while she gave R5 a drink of milk.
- at 6:07 p.m. R5 remained seated in her wheelchair with the attached lap tray in the dining room while NA-E encouraged her to eat by telling her what she had on her plate.
- at 6:14 a.m. R5 was seated in her wheelchair with the attached lap tray in the dining room about two feet from the table, when the director of nursing (DON) approached R5 and asked her if she wanted to eat, R5 refused to respond. The DON tried to give R5 a drink of her cranberry juice and R5 refused.
- at 6:16 p.m. the DON pushed R5 back up to the

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F 604	Continued From page 16	F 604		

table with her lap tray in place, got a chair, sat down next to R5 and gave R5 a bite of her chicken with rice.
- at 6:25 p.m. R5 was seated at the dining room table in her wheelchair with the attached lap tray while the DON continued to feed R5 her supper meal. R5's lap tray was not removed during the supper meal to release the restraint.

During observations of the breakfast meal on 10/19/18 at 8:52 a.m. R5 was seated in her wheelchair with an attached lap tray, at the dining room table. Both wheelchair brakes were locked and R5's tip toes pressed up against the floor. R5 was not able to move in her wheelchair while NA-B assisted R5 to eat her breakfast.
- at 8:58 a.m. NA-B gave R5 bite of her hot cereal and continued to feed R5 her breakfast meal.
- at 9:00 a.m. NA-B asked R5 if she was done eating and R5 indicated she was done eating breakfast. R5 remained seated in the wheelchair with attached lap table, brakes engaged, tip toes pressed against the floor, unable to move in her wheelchair while NA-B assisted her to finish breakfast.
- at 9:01 a.m. NA-B removed R5's multi-colored clothing protector, unlocked the brakes on R5's wheelchair, placed her feet on the wheelchair pedals and wheeled her out of the dining room into the hallway. R5's wheelchair brakes were locked and the lap tray was not removed during the breakfast meal to release the restraints.

During observation of the noon meal on 10/19/18 at 12:29 p.m. R5 was seated in her wheelchair with an attached lap tray at the dining room table. R5 had both brakes locked on her wheelchair,

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F 604	Continued From page 17	F 604		

while her tip toes pressed up against the floor. R5 was not able to move in her wheelchair while NA-G assisted R5 to eat her lunch.
- at 12:32 p.m. NA-G continued to assist R5 eat her lunch while her braked remained locked on her wheelchair and her lap tray remained attached to the wheelchair.
- at 12:36 p.m. licensed practical nurse (LPN)-B confirmed R5's wheelchair brakes were locked and a lap tray was attached to R5's wheelchair while NA-G fed her lunch. NA-G indicated they locked the brakes on R5 wheelchair due to her fidgeting. She verified she was not aware that R5's lap tray needed to be removed during meals.

On 10/18/18 at 2:15 p.m. NA-F confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-F verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals.

On 10/18/18 at 2:49 p.m. LPN-B confirmed R5 needed staff assistance for eating and all ADL's. LPN-B verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and off to the side during meals.

On 10/19/18 at 11:07 a.m. the DON confirmed R5 care plan and indicated R5 needed staff assistance with meals and all ADL's. The DON verified R5 utilized a lap tray on her wheelchair as a restraint due to being a fall risk and per family request. The DON indicated the lap tray was to be removed every two hours and with meals. The DON indicated she was not aware of the lap tray being removed during meals until she reviewed R5's current care plan. The DON

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F 604	Continued From page 18 indicated she would expect staff to follow R5's care plan as written and would expect staff to remove the lap tray during all meals and verified staff should not be locking R5's wheelchair brakes, which would also be a restraint. On 10/19/18 at 12:32 p.m. NA-B confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-B verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals. NA-B indicated she had forgotten to remove the lap tray during the meal and stated it should have been taken off during meals. NA-B also verified R5's brakes had been locked during the meal and indicated staff were not to lock the brakes on wheelchairs. Review of facility policy titled, Restraint Free Care revised on 4/1/2016, indicated physical restraints were only used when they were used appropriately to treat the residents medical symptoms and to promote an optimal level of function for the resident. The policy also indicated a restraint may never be used for the purpose of discipline or staff convenience.	F 604		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		11/28/18

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 623	Continued From page 19	F 623		

Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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F 623	Continued From page 20 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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 623	Continued From page 21 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long Term Care (LTC) Ombudsman of a facility initiated transfer for 1 of 1 resident (R7) reviewed for hospitalization. Findings include: R7's quarterly Minimum Data Set (MDS) assessment dated 7/25/18, identified R7 had moderately impaired cognition, and had diagnoses which included schizophrenia, hemiplegia (one-sided weakness of the body) and Diabetes Mellitus. The MDS indicated R7 required extensive assistance with activities of daily living (ADLs) and had a history of falls. Review of R7's progress notes from 10/1/18, to 10/19/18, revealed: -10/1/18, R7 was found on the floor after roommate came to get the nurse. Staff applied pressure to laceration above right eye until emergency medicals services (EMS) arrived and transported to Detroit Lakes. -10/2/18, R7 was transferred to an Emergency Department (ED) at Essentia hospital. R7 received 3 sutures to forehead. There was no indication the ombudsman had been notified of R7's transfer to the hospital.	F 623	o Long Term Care Ombudsman has been notified of R7 emergency room visit on 10/1/2018 o All other residents with hospitalization beginning October 22, 2018 have been reviewed and Long Term Care Ombudsman update per requirement o Education provided to IDT on fax communication form required monthly to update Ombudsman of transfers and discharges, including emergency care. o Administrator or designee to audit monthly for 3 months o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed. o Compliance date: 11/28/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 623	Continued From page 22 On 10/18/18, at 11:14 a.m. clinical manager (CM)-A stated R7 fell and hit his head on 10/1/18, and was sent to the ED. CM-A was unsure what process the facility utilized for updating the LTC Ombudsman of facility initiated transfers. On 10/18/18, at 11:30 a.m. interim facility administrator indicated she was unaware who updated the LTC Ombudsman of facility initiated transfers, and would have to reference the facility's policy. On 10/18/18, at 12:10 p.m. the facility's operations manager stated updating the LTC Ombudsman of discharges and transfers was part of her role and sent a list of all transfers and discharges to the LTC Ombudsman at the end of every month. The operations manager stated the information on residents to send to the LTC Ombudsman was gathered from a report on the electronic health record system, titled Admit/Discharge To/From Report. She indicated the information for a resident going to the ED and returning would not show up on the report as the resident would not be discharged or transferred. The operations manager was unaware the facility had to update the LTC Ombudsman of facility initiated discharges when a resident was transferred to an acute care facility on an emergency basis. Review of facility policy titled, Admission, Transfer and Discharge (General)- HDGR [Health Dimensions Group], last revised 9/22/17, indicated it was the facility policy to follow all state and federal regulations regarding admissions, transfers, and discharges to and	F 623		

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F 623	Continued From page 23 from the skilled nursing facility. The policy indicated "6. Timings of notice: a) The notice of transfer or discharge is made by the facility at least 30 days before the resident is to be transferred or discharged. Notice will be provided to resident and resident representative as well as state Ombudsman. b) Notice is made as soon as practicable before transfer or discharge when: ... iii. An immediate transfer or discharge is required by the resident's urgent medical needs;..."	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		11/28/18

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F 625	Continued From page 24 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide notification to the resident and/or resident representative of the facility's bed hold policy at the time of an emergency transfer for 1 of 1 resident (R7), reviewed for hospitalization. Findings include: R7's quarterly Minimum Data Set (MDS) assessment dated 7/25/18, identified R7 had moderately impaired cognition, and had diagnoses which included schizophrenia, hemiplegia (one-sided weakness of the body) and Diabetes Mellitus. The MDS indicated R7 required extensive assistance with activities of daily living (ADLs) and had a history of falls. Review of R7's progress notes from 10/1/18, to 10/19/18, revealed: -10/1/18, R7 was found on the floor after roommate came to get the nurse. Staff applied pressure to laceration above right eye until emergency medicals services (EMS) arrived and transported to Detroit Lakes. -10/2/18, R7 was transferred to an Emergency Department (ED) at Essentia hospital. R7 received 3 sutures to forehead. On 10/18/18, at 9:26 a.m. licensed practical nurse (LPN)- A indicated when staff transfer a	F 625	o R7 returned to the facility prior to receiving bed hold o Other residents have received bed hold per policy o Education provided to IDT and licensed nurses to obtain signed bed hold on all transfers including emergency care o Administrator or designee to audit with each transfer for one month and monthly for 2 months o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed. o Compliance date: 11/28/2018	

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F 625	Continued From page 25	F 625		

resident to the hospital we ask the resident or their emergency contact of they want a bed hold. LPN-A stated "we are supposed to ask [regarding a bed hold], but sometimes it gets missed". LPN-A indicated a form would be filled out at the time of the transfer called Bed Hold Policy, by the nurse that was transferring the resident. LPN-A stated she was not sure that the form was used for residents transferred to the ED, but was used if the resident was to be admitted to the hospital.

On 10/18/18, at 9:38 a.m. social service designee (SSD)-A indicated he had no part of the facility's bed hold process.

On 10/18/18, at 11:14 a.m. clinical manager (CM)-A indicated if a resident went to the hospital the nurse on the floor, or social worker, would offer the bed hold form. She stated the form would be filled out by staff and placed in the front of the resident's medical record chart, and then filed under the Social Services tab of the chart after the resident returned to the facility. CM-A stated staff would not offer the bed hold form if a resident was going to the ED and the staff knew they would not be admitted. She indicated if a resident was admitted to the hospital from the ED, then staff would complete the bed hold form at that time.

On 10/18/18, at 11:30 a.m. interim facility administrator stated the facility's bed hold form should be offered to the resident "on the way out the door, if possible". She indicated if not possible to offer upon transfer, it should be completed within a day. The administrator indicated she would expect staff to follow the facility's policy.

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F 625	Continued From page 26 On 10/18/18, at 12:28 p.m. CM-A reviewed R7's medical record and confirmed a bed hold was not offered to R7 on 10/1/18, due to R7 only going to the ED and not being admitted to the hospital. A facility policy titled, Bed Hold and Re-Admission, last revised 11/16, indicated before a resident was transferred to a hospital or placed on therapeutic leave, written notification was provided to the resident, and/or the resident representative.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 3 residents (R38) who were dependent upon staff for activities of daily living. Findings include: R38's admission Minimum Data Set (MDS), dated 9/28/18, identified R38 had diagnoses which included dementia, heart failure and seizure disorder. The MDS identified R38 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, transfers, personal hygiene, dressing and toileting. Further, the MDS identified R38 was occasionally incontinent of bowel and frequently	F 677	o R38 had discharged from the community o Other residents identified as dependent on staff for incontinence have been reviewed and provided care timely o Education provided to nursing staff on timely incontinence care for dependent residents o DON or designee to audit 3 residents two times weekly for four weeks and then weekly for one month and then monthly for 2 months o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed. o Compliance date: 11/28/2018	11/28/18

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 677	Continued From page 27 incontinent of bladder, and was not on a bowel or bladder toileting program. R38's care area assessment (CAA) dated 9/28/18, indicated R38 was incontinent of bowel and bladder, was unable to make her needs known, unable to sit on the toilet and was incontinent of bowel and bladder at all times. The CAA also indicated R38 had diagnoses of congestive heart failure and was receiving diuretics to keep fluid off of her extremities and heart, which increase her risk for incontinence. The CAA further indicated R38 was at risk for skin breakdown and odor related to incontinence and staff would anticipate R38's needs. R38's Bowel and Bladder Functional Evaluation dated 9/25/18, indicated R38 had incontinence of bowel and bladder, unable to feel urge/sensation to void/defecate and had functionally incontinent related to dementia, impaired mobility and dependent on staff for all cares, ADL's and staff to check/change. R38's current care plan revised on 10/15/18, identified R38 had self care deficits related to urinary incontinence, constipation, dementia, weakness, generalized pain and malnutrition. The care plan listed various intervention which directed staff to check/change for incontinence upon rising, before and after meals, at bedtime and with night rounds and as needed. Review of Aide Guide for Group A undated, indicated R38 was incontinent of bowel/bladder and directed staff to check/change upon rising, before and after meals, at bedtime and check/change with rounds at night.	F 677		

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F 677	Continued From page 28	F 677		

Continual observations were conducted on 10/17/18 from 5:08 p.m. to 7:55 p.m.
- at 5:08 p.m. R38 was seated in her Broda chair in her room watching TV.
- at 5:15 p.m. R38 remained the same and the director of nursing (DON) stopped in room, peaked at R38 and left the room.
- at 5:29 p.m. DON wheeled R38 out of her room via Broda chair down to the dining room and pushed her up to the dining room table.
- at 5:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of her thickened water.
- at 5:59 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots.
- at 6:12 p.m. NA-E continued to assist R38 to eat her supper.
- at 6:20 p.m. NA-E asked R38 if she was done eating, wiped her mouth, removed her clothing protector from her chest area, wheeled R38 out of the dining room via Broda chair and back to her room. NA-E reclined R38's Broda chair back slightly, placed call light, made resident comfortable and left her room.
- at 6:48 p.m. R38 remained in her room seated in her Broda chair and was watching TV.
- at 7:02 p.m. R38 remained in her room seated in her Broda chair, TV on and R38's eyes were closed while she rested.
- at 7:05 p.m. activity staff entered R38's room, asked if she want to come to activity, activity staff wheeled R38 out of her room via Broda chair down to the activity room where they were singing and having bible class.
- at 7:22 p.m. R38 remained seated in her Broda

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 677	Continued From page 29	F 677		

chair while she continued to listen to singing in the activity room.
- at 7:38 p.m. activity staff pushed R38 back to her room via Broda chair and left the room.
- at 7:41 p.m. R38 remained in her room seated in her Broda chair and R38's eyes were closed while she rested.
- at 7:45 p.m. NA-D enter R38's room with full mechanical lift and began to assist R38 to get ready for bed while NA-E entered the room to help.
- at 7:51 p.m. NA-D and NA-E continued to assist R38 to get ready for bed by washing her up and putting her pajama's on her upper body.
- at 7:55 p.m. NA-D and NA-E positioned the full mechanical lift over R38, hooked R38 to the mechanical lift and transferred her from her Broda chair to the bed. NA-D and NA-E proceeded to roll R38 from side to side, removed the lift sling, NA-D removed R38's pants, NA-E confirmed R38 was incontinent of bowel and bladder and they proceeded to change R38's incontinent products. During observation R38's buttocks was noted to be bright red around the rectal area which extended to the outer edges of her buttock crease to be more pink with no open areas noted. R38 had not been check/changed for a total of 2 hours and 47 minutes even though she was dependent upon staff for incontinence care and was at risk for skin breakdown.

On 10/18/18 at 11:54 a.m. NA-F confirmed R38 was routinely incontinent of bowel and bladder and needed to be checked/changed every two hours.

On 10/18/18 at 12:16 p.m. licensed practical nurse (LPN)-B confirmed R38 was routinely

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 677	Continued From page 30 incontinent of bowel and bladder and had to be checked and changed every two hours, an was at risk for skin breakdown. On 10/19/18 at 10:46 a.m. the DON verified R38 was at risk for skin breakdown and pressure ulcers and would expect staff to check/change as identified by the care plan. On 10/18/18 at 2:51 p.m. NA-E called via phone call confirmed R38 required assistance of two staff with all cares and was incontinent of bowel/bladder and wore incontinent products. NA-E indicated R38 required staff to checked/changed her every two hours. NA-E verified R38 had not been checked/change before or after the supper meal and stated we tried to get in there right away. Review of facility policy titled, Bowel and Bladder Management revised on 11/16, indicated there's a system to ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 31 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with repositioning for 1of 1 resident (R38) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: R38's admission Minimum Data Set (MDS), dated 9/28/18, identified R38 had diagnoses which included dementia, heart failure and seizure disorder. The MDS identified R38 required extensive assistance of two staff for bed mobility and transfers. The MDS further identified R38 was at risk for the development of pressure ulcers and listed various treatments which included pressure relieving devices for chair and bed. R38's care area assessment (CAA) dated 9/28/18, indicated R38 was at risk for and had history of skin break down related to pressure to coccyx and open area, which had been resolved and remained at risk for further skin breakdown. The CAA also indicated R38 utilized a pressure relieving mattress and pressure relieving pad in wheelchair, needed staff assistance for all mobility, was unable to move self in bed and was able to participate with staff to reposition. The CAA further indicated R38 was at risk for pressure ulcers related to malnutrition, chronic or end stage renal, liver, heart disease, dementia,	F 686	o R38 has discharged from the community o All other residents identified at risk for pressure ulcers have had an assessment and care plan review and revised as indicated o Education provided to nursing staff on timely repositioning to prevent pressure injury development o Audit of interventions to prevent pressure ulcers will be completed on 3 residents two times weekly for four weeks and then weekly for one month and monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 11/28/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 686	Continued From page 32	F 686		

immobility and staff were to ensure to do repositioning.

R38's Braden Scale for Predicting Pressure Sore Risk form, dated 9/25/18, identified R38 was at high risk for the development of pressure ulcers, skin was often very moist, was chair fast, had very limited mobility, probably inadequate nutrition and had a problem of friction and shearing. The form indicated R38 was at risk for skin breakdown and required total assistance from staff for all cares, activities of daily living (ADL's) and mobility.

R38's current care plan revised on 10/15/18, identified R38 had self care deficits and skin breakdown related to dementia, incontinence, impaired mobility, weakness, generalized pain, malnutrition and dependent on staff for all cares. The care plan directed staff to turn and reposition upon rising, before and after meals, at bedtime and with rounds during night hours.

Review of Aide Guide for Group A undated, indicated R38 was high risk for skin breakdown and directed staff to turn and reposition upon rising, before and after meals, at bedtime and with rounds during night shift.

Continual observations were conducted on 10/17/18 from 5:08 p.m. to 7:55 p.m.
- at 5:08 p.m. R38 was seated in her Broda chair in her room watching TV.
- at 5:15 p.m. R38 remained the same and the director of nursing (DON) stopped in room, looked at R38 and immediately left the room.
- at 5:29 p.m. DON wheeled R38 out of her room via Broda chair down to the dining room and

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F 686	Continued From page 33	F 686		

pushed her up to the dining room table.
- at 5:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of her thickened water.
- at 5:59 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots.
- at 6:12 p.m. NA-E continued to assist R38 to eat her supper.
- at 6:20 p.m. NA-E wiped R38's mouth, removed her clothing protector from her chest area, wheeled R38 out of the dining room via Broda chair and back to her room. NA-E reclined R38's Broda chair back slightly, placed call light, made resident comfortable and immediately left the room.
- at 6:48 p.m. R38 remained in her room seated in her Broda chair and was watching TV.
- at 7:02 p.m. R38 remained in her room seated in her Broda chair, TV on and R38's eyes were closed while she rested.
- at 7:05 p.m. activity staff entered R38's room, asked if she want to come to activity, activity staff wheeled R38 out of her room via Broda chair down to the activity room where they were singing and having bible class.
- at 7:22 p.m. R38 remained seated in her Broda chair while she continued to listen to singing in the activity room.
- at 7:38 p.m. activity staff pushed R38 back to her room via Broda chair and left the room.
- at 7:41 p.m. R38 remained in her room seated in her Broda chair and R38's eyes were closed while she rested.
- at 7:45 p.m. NA-D enter R38's room with full mechanical lift and began to assist R38 to get ready for bed while NA-E entered the room to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 686	Continued From page 34	F 686		

help.
- at 7:51 p.m. NA-D and NA-E continued to assist R38 to get ready for bed by washing her up and putting her pajama's on her upper body.
- at 7:55 p.m. NA-D and NA-E positioned the full mechanical lift over R38, hooked R38 to the mechanical lift and transferred her from her Broda chair to the bed. NA-D and NA-E proceeded to roll R38 from side to side, removed the lift sling, NA-D removed R38's pants. NA-E confirmed R38 was incontinent of bowel and bladder and they proceeded to change R38's incontinent products. During observation R38's buttocks was noted to be bright red around the rectal area which extended to the outer edges of her buttock crease to be more pink with no open areas noted.

R38 had not offered to reposition before and after meals as directed by her care plan and was unable to reposition herself independently. R38 had not been repositioned for a total of 2 hours and 47 minutes and was at high risk for pressure ulcers.

On 10/18/18 at 11:54 a.m. NA-F confirmed R38 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed.

On 10/18/18 at 12:16 p.m. licensed practical nurse (LPN)-B confirmed R38 was routinely incontinent of bowel and bladder, needed to be repositioned checked/changed and R38 was at risk for pressure ulcers.

On 10/19/18 at 10:46 a.m. the DON confirmed R38 required total assistance with ADL's and was

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 686	Continued From page 35 routinely incontinent of bowel and bladder, needed to be checked/changed, turned and reposition upon rising, before and after meals, at bedtime and with rounds during night shift. The DON verified R38 care plan, verified she was at risk for pressure ulcers and she would expect staff to turn and reposition R38 as per her schedule and to follow her care plan. On 10/18/18 at 2:51 p.m. via telephone interview, NA-E confirmed R38 required assistance of two staff with all cares and was incontinent of bowel and bladder and wore incontinent products. NA-E indicated she was not sure if R38 was at risk for pressure ulcers, but required staff to reposition her every two hours and checked/changed her. NA-E verified R38 had not been repositioned or checked/change before or after the supper meal and stated we tried to get in there right away.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 36 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive assessment and implement appropriate interventions to prevent a decline or maintain current range of motion (ROM) abilities for 1 of 2 residents (R18) reviewed with limited ROM. Findings include: R18's admission Minimum Data Set (MDS) dated 8/23/18, identified R18 had diagnoses which included; dementia, hemiplegia (weakness on one side of the body), and aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write). R18's MDS further identified R18's cognition was severely impaired and required extensive assistance with bed mobility, dressing, eating, personal hygiene, and required total assistance for transfers, locomotion, and toilet use. R18's MDS also identified no rejection of care, and a functional limitation in range of motion on one side of her upper and lower extremities. Review of R18's Care Area Assessments (CAA) dated 8/29/18, identified R18 rarely/never verbalized her needs and was dependent on staff for all activities of daily living (ADL) due to her cognitive impairment and deficits from her stroke years ago. The CAA further identified, R18 had limited understanding of others and would have	F 688	o R18 has been screened and care plan revised for proper intervention for contracture o All other residents with contractures screened and care plans revised as indicated o Education will be provided to nursing admin., functional maintenance O.T. and therapy on the need for screening residents with contractures on admission and routinely to ensure appropriate treatment to maintain or prevent decline in range of motion. o Audit to assure ROM and splints are used as indicated/ordered on 5 residents two times weekly for four weeks and then weekly for four weeks and then monthly for two months to prevent decline in ROM. o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date 11/28/2018	

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 688	Continued From page 37	F 688		

physical behaviors during cares and verbal behaviors of yelling out during cares as she did not understand, and staff may have to re-approach. The CAA also identified R18 had partial or total loss of arm movement, functional limitation in range of motion, hemiplegia, and inability to perform ADLs without significant physical assistance.

R18's care plan, last revised 10/19/18, identified R18 had decreased mobility of right hand due to hand in flexed position. R18 was dependent on staff for all ADLs and mobility. R18's ADLs portion of care plan listed FMP as allows. R18's behaviors section of the care plan indicated R18 had verbal and physical behaviors during cares related to severe cognitive impairment and limited understanding due to her diagnosis of dementia and deficits as a result of her cardiovascular accident (CVA) (stroke). Target behaviors included; hitting slapping and attempt to bite during cares. She would yell out during cares, often yelling "owa". Husband stated this was not pain related but feels she yells "owa" because someone is touching her and she doesn't understand. Various interventions were listed which included; "give her something to occupy her left hand when providing cares, such as a washcloth, to distract her from physical behaviors during care".

R18's Aide Care Guide Group B, dated 9/23/18, identified R18 required extensive assistance from one to two staff, was non-ambulatory, and had a tendency to hit out and yell with cares. The guide instructed staff to try and place something in her left hand to hold during cares, and was a high risk for skin concerns.

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F 688	Continued From page 38	F 688		

Review of the physician progress note dated 5/5/18, indicated it was a nursing home admission history and physical. Under physical exam the note indicated "Musculoskeletal: Right hand somewhat flexed, right hemiparesis".

On 10/16/18, at 9:44 a.m. R18 was observed seated in a wheelchair with eyes opened. R18's right hand was clenched into a fist, and no device or material were noted in the right hand. R18's right foot was flexed and rested against the foot rest of the wheelchair. Family member (FM)-A was present and stated R18's right hand had been like that for a long time. FM-A stated he visited daily, and was not aware if R18 had any ROM exercise program.

On 10/16/18, at 2:10 p.m. R18 was lying on her back in bed with her eyes open and the television was on. R18's right hand remained clenched into a fist.

On 10/17/18, at 1:18 p.m. R18 was lying on her back in bed with the head of the bed raised, eyes were open and the television was on. R18's right hand remained clenched into a fist.

On 10/17/18, at 5:13 p.m. R18 was seated in the wheelchair, which was slightly reclined, at the dining room table. R18's right hand was positioned in her lap and her right hand remained clenched in a fist. R18's right foot remained flexed and rested on a pillow on the footrest of the wheelchair.

R18's progress notes reviewed from 8/1618, to 10/16/18, revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 688	Continued From page 39 -8/29/18, R18 yelled out when certified occupation therapy assistant (COTA) attempted to do passive ROM (PROM) then refused any further ROM. R18 would continue with current FMP, PROM bilateral lower extremities (LE) and upper extremities (UP) 3-5 times per week. R18 was new to program that week. -9/5/18, R18 denied pain when left arm lifted, and yelled ow when attempted to mover her right hand. "[S]he holds her right hand together tightly". -9/12/18, therapy note; R18 was provided with a different wheelchair for use in facility to improve posture and sitting tolerance. -9/14/18, R18 refused FMP this date. -9/18/18, R18 refused to let COTA touch them without yelling out this date, so PROM not done this date per R18's refusal. -9/19/18, refused FMP this date. -9/25/18, PROM B LE and UE. -9/28/18, "PROM B LE and UE 1 to 3 times per week. Active participation. Continue no change." -10/2/18, R18 not seen this date for FMP due to sleeping. -10/3/18, R18 was asleep and therefore was not seen for FMP. -10/5/18, R18 was sleeping when COTA	F 688		

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 688	Continued From page 40 attempted to see. -10/10/18, refused FMP this date. -10/16/18, PROM bilateral LE and left elbow and wrist. On 10/18/18, at 10:08 a.m. physical therapist (PT)-A indicated R18 was admitted for long-term care and did not have admission therapy orders. PT-A stated, if residents were admitted to long term care, they would be screened for any concerns. PT-A stated he would check therapy records for R18's screen. On 10/18/18, at 10:33 occupational therapist (OT)-A stated R18 was admitted for long term care without therapy orders. OT-A indicated, therapy would not see the newly admitted resident without therapy orders, and would depend on nursing staff to notify therapy staff if a screen would be needed for a possible functional maintenance program (FMP). OT-A stated OT would screen residents with limited ROM or possible contractures (condition of fixed high resistance to passive stretch of a muscle) to place them on a FMP to complete stretching and ROM to decrease any further contraction. OT-A confirmed R18 had only one screen from therapy for a wheelchair assessment. OT-A confirmed R18 was on a FMP, but no documentation of a screen for FMP was available. On 10/18/18, at 10:41 a.m. OT-A entered R18's room and evaluated R18's right hand for possible contractures. OT-A opened R18's right hand and R18's skin was pale/white in appearance and appeared macerated (moist, soft and in a state of	F 688		

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 688	Continued From page 41	F 688		

deterioration). OT-A held R18's hand open and indicated the palm and finger area had to dry out. OT-A stated R18 would benefit from a splint or hand roll. At 10:44 a.m. FM-A entered R18's room and stated R18 used to have a roll or a wash cloth in her right hand at a previous facility. OT-A evaluated R18's right foot and indicated R18 would benefit from a brace to the right foot.

On 10/18/18, at 10:45 a.m. OT-A stated R18 was at risk for worsening contractures, and confirmed R18 had not had a splint, brace, or hand roll while at the facility. OT-A stated she would have expected the certified occupational therapy assistant (COTA) responsible for administering R18's FMP to have updated therapy on the state of R18's right hand and R18's refusing FMP to the right hand. OT-A confirmed therapy had not received any concerns related to R18, other then her wheelchair screen.

On 10/18/18, at 2:46 p.m. during an phone interview with COTA-A, she stated she was responsible for completing R18's FMP and was scheduled for 1 to 3 times per week. COTA-A indicated all documentation for the FMP was in R18's progress notes. COTA-A indicated she would work with R18 usually once per week. She stated, normally if she could work with R18 it was to complete her lower extremity ROM. COTA-A stated the last time she worked with R18, she did allow her to complete ROM on R18's left upper extremity. COTA-A stated she had never been able to touch R18's right upper extremity due to R18 stating no, or would yell at her. She indicated she would report to nursing or therapy any changes with R18, or anything new. COTA-A indicated R18 was admitted without therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 688	Continued From page 42 orders, so she assumed the facility had a plan for R18. COTA-A stated she had not seen R18 with any device or wash cloth in her right hand. On 10/18/18, at 11:06 clinical manager (CM)-A stated if nursing staff noted a contracture, they would update the nurse, and the nurse would fill out a therapy screen and get physician orders for therapy. CM-A stated R18 had diagnoses of CVA and hemiplegia, and was at risk for contractures. On 10/18/18, at 2:16 p.m. nursing assistant (NA)-J stated she regularly worked with R18. NA-J stated in the mornings, she would have to open R18's right hand and wash it with soap and water due to an odor. NA-J stated staff would at times place a wash cloth in R18's left hand so she would have something to hold on to. On 10/19/18, at 11:27 a.m. director of nursing (DON) stated if a resident was admitted with a contracture, she would expect something to be in place to address it. She would have expected the staff responsible for R18's FMP to update nursing or therapy of R18's refusal to work with the right hand so a screen could have been completed. Review of facility policy titled Rehabilitation Services Orders dated 4/1/08, indicated the facility provided physical, occupational, or speech therapy to attain or maintain function and/or prevent decline with a physician-ordered treatment plan. A policy for identifying contractures, splint or brace use was requested and none were provided.	F 688		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689 SS=D	Continued From page 43 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall interventions for 1 of 2 residents (R7) reviewed for accidents, and failed to implement safe transfer requirements for 1 of 2 residents (R7) observed using a mechanical lift. In addition, the facility failed to implement safe smoking interventions for 1 of 3 residents (R40) who required staff to manage smoking materials. Findings include: ' FALLS R7's significant change in status Minimum Data Set (MDS), dated 4/26/18, identified R7 had severe cognitive impairment and had diagnoses which included hemiparesis (one-sided weakness of the body), schizophrenia, and Diabetes Mellitus. The MDS indicated R7 required total assistance from staff for transfers, and extensive assistance for bed mobility, eating, toilet use, and personal hygiene. The MDS further indicated R7 had a history of falling. Review of R7's quarterly MDS, dated 7/25/18, identified R7 had moderately impaired cognition,	F 689	o R7 had O.T screen for safe wheel chair positioning 10/18/2018 o R7 had anti-roll brakes added to wheelchair 10/18/2018 o R7 has been using total lift per care plan o R40 has been re-educated on her smoking assessment and requirements to have facility staff store her smoking material, additionally, R40 was re-educated on the policy and acknowledgment for smoking at Frazee Care Center. o All residents who had falls in the last 30 days have been reviewed to ensure stated interventions are in place o All residents care guides reviewed to ensure proper lift is reflected for safe transfer o All residents identified as smokers have had their assessment reviewed and care plan and care guide updated to reflect current assessment findings o All residents have had smoking policy reviewed and sign acknowledgement of understanding	

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F 689	Continued From page 44 and had diagnoses which included palliative care (managing the symptoms and side-effects of life-limiting and chronic illness), hemiparesis, schizophrenia, and Diabetes Mellitus. The MDS indicated R7 required total assistance for transfers with two or more staff. The MDS further indicated R7 had two or more falls since the last assessment. Review of R7's Care Area Assessments (CAA), dated 5/9/18, identified R7 displayed poor judgement and safety awareness with poor decision making as evidenced by attempts to self transfer, which resulted in falls. The CAA indicated R7 believed he could stand and attempted to do so in order to self transfer from the wheelchair to bed. The CAA also indicated, R7 had a history of a stroke which resulted in right sided hemiparesis, was unable to walk or stand, was a fall risk, and required a full body lift for transfers. Review of R7's care plan, last revised 10/5/18, indicated R7 was at risk for falls related to a history of falls due to self transfer attempts, as R7 believed he could still stand and walk, incontinence, balance issues, and right sided hemiparesis. R7's care plan listed various interventions which included a low bed, physical therapy to assess for proper wheelchair fitting status post fall, and mechanical lift to transfer with total assist of two staff. Review of the Aide Care Guide Group B, dated 9/23/18, indicated R7 used a wheelchair, had a high-low bed, required extensive assistance with activities of daily living and transferred with total assist of two staff and a mechanical lift.	F 689	o Nursing staff and IDT educated on falls and the importance of interventions to reduce or minimize risk of injury. o Nursing staff educated on following what care guide designates for safe transfers o Nursing staff educated with return demonstration on proper use of the lift machines o Employees will be given training on facility expectations related to smoking policy and procedure including the following: designated resident smoking areas that can be used for smoking, per policy; residents are not allowed to share smoking materials or assist other residents in smoking. Additionally, failure to follow the safety expectations may result in loss of smoking privileges. o Audits of new interventions will occur two times weekly for four weeks and then weekly for one month and then monthly for 2 months o Audits of proper transfer lift use will occur two times weekly for four weeks on 3 residents and then weekly for one month and then monthly for two months o Audits of following individualized smoking plan to be completed for 2 residents two times per week for four weeks and then weekly for one month and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance Date 11/28/2018	

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 689	Continued From page 45 During observation on 10/17/18. at 1:43 p.m. R7 was lying in a low bed with his wheelchair positioned next to the bed near the bed rail. R7's wheelchair brakes were not locked. R7 stated he was able to get himself up and to the wheelchair without help from staff, and was able to use the bathroom independently as well. R7 stated he had fallen a couple weeks ago and hit his head. R7 stated he went to the hospital and received sutures for a head wound. Review of R7's progress notes from 10/1/18, to 10/19/18, revealed: -10/1/18, R7 was found on the floor after roommate came to get the nurse. Staff applied pressure to laceration above right eye until emergency medicals services (EMS) arrived and transported to Detroit Lakes. -10/2/18, interdisciplinary team (IDT) met to review R7's fall. R7 attempted a self transfer from wheelchair to bed and fell to the floor, lacerating his forehead. R7 had right sided weakness that increased fall risk, and used a full body lift for transfers. Discussed with nursing staff and was noted R7 does not frequently apply brakes to the wheelchair and was unable to bear weight on his own. IDT decided to add auto[matic] brakes (device that automatically locked the wheels whenever the person stands or sits) to wheelchair for improved safety. -10/3/18, R7's auto brakes are on order and not yet at facility. Physical therapy (PT) will assess for proper wheelchair use and positioning, as R7 was noted to slide in wheelchair as he self	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 689	Continued From page 46	F 689		

propels. Staff will add auto brakes when they arrive at facility.

On 10/17/18, at 6:43 p.m. R7 was seated in the wheelchair and was pushed to his room by nursing assistant (NA)-H. The director of nursing (DON) followed them into the room with a mechanical lift. At 6:47 p.m. R7 was transferred to bed by NA-H and the DON, and bedtime cares were completed. At 6:55 p.m. R7's bed was lowered to the floor, he was given a call light, and NA-H placed the wheelchair next to R7's bed. NA-H and the DON left the room. R7's wheelchair brakes were not locked and the wheelchair lacked auto brakes.

On 10/17/18, at 6:57 p.m. NA-H stated R7 required two staff for the majority of cares, but once in bed one staff could complete some cares as R7 could assist with bed mobility and understood instructions. She stated staff placed him in a low bed due to many self transfer attempts and risk for falls.

On 10/17/18, at 7:27 p.m. NA-I stated R7 required extensive assistance with cares and was a fall risk. NA-I stated when R7 wanted to do something, like go to bed, you have to be quick as he would try to do things on his own.

On 10/18/18, at 9:26 a.m. licensed practical nurse (LPN)-A stated R7 required extensive assist with two staff for cares, and required a mechanical lift and two staff for all transfers. LPN-A indicated R7 was at risk for falls due to self transfer attempts.

On 10/18/18, at 9:40 a.m. PT-A indicated R7 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 689	Continued From page 47 not recently been evaluated by therapy. On 10/18/18, at 2:08 p.m. R7 was lying in bed with eyes closed. The bed frame remained elevated approximately two feet off the floor, with R7's wheelchair positioned near the bed. The wheelchair's locks were not applied and the wheelchair lacked auto brakes. NA-A entered R7's room and stated the day shift would have laid R7 in bed after lunch. NA-A stated R7 was a fall risk and should be in a low bed when occupied. NA-A lowered R7's bed to the floor and left the room as R7's wheelchair remained unlocked. On 10/18/18, at 11:14 a.m. clinical manager (CM)-A stated R7 required maximum assistance with all activities of daily living and was transferred with two staff and mechanical lift at all times. CM-A stated R7 was at risk for falls and her expectation for staff would be to follow R7's care plan and the care guides. CM-A stated R7 had a fall on 10/1/18, which required sutures at the emergency department. After the fall, staff implemented wheelchair auto brakes as an intervention to prevent future falls. CM-A indicated she was not aware the wheelchair brakes had not been placed on R7's wheelchair. On 10/19/18, at 11:42 a.m. the DON stated R7 required assistance with activities of daily living, was at risk for falls and injuries, and required two staff and mechanical lift for all transfers. The DON stated after R7's fall on 10/1/18, the IDT reviewed the incident and implemented auto brakes for R7's wheelchair. She indicated maintenance updated her that the wheelchair brakes were ordered, but not available on	F 689		

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 689	Continued From page 48	F 689		

10/3/18. The DON stated after she learned the auto brakes would not be readily available, she verbally asked therapy to assess R7's wheelchair use. The DON confirmed R7 was not assessed by therapy, as a therapy order was not received and the proper form was not completed. She stated she would have expected the therapy assessment to have been completed more timely. The DON stated R7's bed should be in the low position when occupied, and stated she expected staff to lower R7's bed when he was lain in bed.

In addition:

MECHANICAL LIFT
On 10/17/18, at 2:23 p.m. R7 was seated at the edge of bed with the bed approximately at knee height. R7 had an EZ-Way Stand (mechanical standing transfer equipment) positioned directly in front of him. R7 had a beige (medium) colored harness around his back, which was attached to the EZ-Way Stand's hydraulic arms. NA-I stood behind the machine's controls and attempted to raise the hydraulic arms, but the machine did not move. NA-I stated the battery had died, she removed the battery and left the room with R7 sitting at the edge of the bed, with harness behind him and feet on the stand's foot plate. As NA-I retrieved a different battery, R7 stated he used this machine often. At 2:25 p.m. NA-I returned to R7's room and placed a different battery. At 2:26 p.m. NA-I raised the arms of the machine which assisted R7 to a semi-standing position. R7 held onto the machine's hand grips with his left hand, as he was unable to hold on to the machine with his right hand. The EZ-Stand's harness was under R7's left arm, but R7's right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 49	F 689		

elbow rested on the middle of the harness on the right. The harness buckle strap was closed loosely around R7's waist. As R7 was raised by the standing machine, NA-I stood behind the machine and did not attempt to tighten the harness's buckled strap, around R7's torso. NA-I then moved the EZ-Stand, with R7 holding on to the machine with one hand and his right elbow pushing against the harness on the right, towards R7's bathroom. NA-I stopped before R7's bathroom, removed R7's pants and an incontinent brief, and pushed R7 and the machine into the bathroom. NA-I then pushed R7 into the bathroom. As R7's buttocks neared the toilet, NA-I had to raise R7 higher in the EZ-Stand to get his buttocks over the arm rest of the toilet. R7 remained holding onto the machine with only his left hand and his elbow rested in the harness. NA-I then lowered R7 onto the toilet and left him attached to the EZ-Stand machine and left the bathroom. At 2:29 p.m. NA-I stated she worked for a nursing agency, and had worked at the facility for two months. At 2:32 p.m. R7 stated he was done using the toilet and NA-I entered R7's bathroom. NA-I used the machine's controls and raised R7 to a semi-standing position. NA-I completed perineal cares and pulled the EZ-Stand machine, with R7, out of R7's bathroom. As NA-I maneuvered the EZ-Stand towards a bath chair, the harness around R7 began sliding up his back. R7's right elbow remained positioned on the harness, with his right hand pulled closely to his chest. The harness buckle had moved up from his lower abdomen to his upper chest and R7's right foot was positioned off of the foot plate. At 2:34 p.m. NA-I lowered R7 onto a bath chair. When R7 was seated in the bath chair, the lower border of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 50 EZ-Stand harness was around R7's upper back, with the upper border of the harness at R7's upper neck. Near R7, in the bath chair, was R7's wheelchair. In the seat of the R7's wheelchair was a sling for the EZ-Lift (mechanical lifting transfer equipment) machine. At 2:37 p.m. NA-I removed the rest of R7's clothing and placed a bath robe on R7 and pushed the bath chair from R7's room to the tub room. On 10/17/18, at 2:57 p.m. R7 was seated in the bath chair, covered in the bath robe, back in his room after a bath. The EZ-Stand machine was again positioned in front of him. At 2:59 p.m. NA-I picked up the beige EZ-Stand harness and placed it behind R7 in the same position as above, except positioned the right side of the harness onto R7's right elbow, which was inside the bathrobe's sleeve. NA-I buckled the harness around R7's abdomen and pulled the buckle strap tighter. NA-I placed R7's feet onto the foot plate and applied the calf strap, then used the controls to raise the EZ-Stand's hydraulic arms. R7 stood up, while holding onto the machine's hand grips using his left hand, as his right hand was inside the bathrobe. As the machine assisted R7 to a standing position, the harness buckle strap became looser, and NA-I did not attempt to pull the buckle's strap tighter. At 3:05 p.m. R7 was lowered by the machine onto the edge of the bed. NA-I removed the machine's harness and assisted R7 to lay flat and assisted R7 to dress. At 3:09 p.m. NA-I pushed R7's wheelchair near the bed and locked the wheels. NA-I then picked up an EZ-Lift sling that was on the wheelchair's seat and placed the sling on a stand near the bed. At 3:10 p.m. NA-I moved the EZ-Stand machine to the side of R7's bed near	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 689	Continued From page 51	F 689		

the bed rail. NA-I tried to assist R7 to sit up at the edge of the bed, but R7 was unable to assist in the bed mobility. NA-I then placed a transfer belt on R7 and raised the head of R7's bed. NA-I then grabbed around R7's upper back with the right arm and held onto the transfer belt with the left arm and tried to assist R7 to an upright seated position at the side of the bed. R7's right side remained slumped back and leaned to the left. NA-I placed the EZ-Stand harness around R7's back, while holding R7 in a seated position utilizing the transfer belt. At 3:14 p.m. R7 stated "I'm not sitting right" as NA-I continued to attempt to place the machine's harness. At 3:16 p.m. NA-I attached the harness to the EZ-Stand machine and stated "you are not seated well", and gave R7 instructions to hold onto the machines handle. At 3:18 p.m. NA-I started to raise the EZ-Stands mechanical arm, attempting to assist R7 to sit straight in front of the machine. At 3:20 p.m. NA-H knocked and entered R7's room. NA-H stated to NA-I "we can lay him down and use the hoyer [EZ-Lift], since he is tired". At 3:22 p.m. NA-H asked R7 if he preferred to lay in bed and nap and R7 answered "yes". NA-I and NA-H removed the EZ-Stand harness and assisted R7 to lay down, and the two staff boosted R7 up in bed, lowered the bed and left the room.

On 10/17/18, at 6:57 p.m. NA-H stated R7 required two staff for the majority of cares, but once in bed one staff could complete some cares as R7 could assist with bed mobility and understood instructions. NA-H stated if R7 wanted to use the commode (portable toilet) or toilet staff could use the EZ-Stand to transfer him. NA-H stated R7's abilities to assist varied, and he

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 52 transferred mostly with two staff and the EZ-Lift. NA-H indicated the use of the EZ-Stand depended on how R7 was doing that day, and if he was too tired, staff would use the EZ-Lift. NA-H stated staff were trained on the mechanical transfer equipment on hire, and thought maybe annually as well. NA-H stated if staff had questions on R7's care they could refer the the care guides or the nurses. On 10/17/18, at 7:27 p.m. NA-I stated R7 required extensive assistance with cares and was a fall risk. NA-I stated when R7 wanted to do something, like go to bed, you have to be quick as he would try to do things on his own. NA-I stated R7 transferred mostly with two staff and the EZ-Lift, but at times used the EZ-Stand. NA-I stated she used the EZ-Stand with R7 at least once a shift, as she could use the standing transfer equipment with only one staff present. NA-I stated R7 struggled with the EZ-Stand today, and if the transfer does not go well with the Stand we would use the Lift. NA-I stated it was good for R7 to use the standing transfer machine as he would get to exercise his legs, and when he used the Lift his legs just lay there in the air. NA-I indicated R7's care plan would instruct how to transfer R7, or the care guide. NA-I checked for the care guide and could not find one. At 7:36 p.m. NA-I found her care guide at the nurse's station and confirmed R7 was to be transferred with two staff and the hoyer [EZ-Stand]. NA-I indicated when she started at the facility other NAs showed her the EZ-Way machines, and she had used the EZ-Way machines at a facility in the past. NA-I indicated she was not aware if a competency check was completed on the facility's EZ-Way Lift or Stand.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 53 Review of the facility provided EZ-Way, Inc. EZ Way Stand Operator's Instructions, undated, indicated "Transferring the patient: Attach harness 1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3 inches below the underarm. 2) For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. ... Raise the patient 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. 2) With hand control in-hand stand beside the patient. ....Press the up button. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso." On 10/18/18, at 9:40 a.m. PT-A stated when residents are first admitted they are screened by therapy to see if they required the transfer lift or stand. PT-A stated after, nursing staff will update therapy if the resident had changed and we would get an updated screen to see if new recommendations were needed. PT-A stated R7's last screen was some time ago and he would have to check R7's records. PT-A stated a harness placement that was not under both arms, or having one arm under clothing while transferring would not be safe. At 10:14 a.m. PT-A confirmed R7's last safety screen with transfers was 11/17, and therapy's recommendation would be to continue to use EZ-Lift and two staff for all transfers for R7's safety. Review of Pro Rehab Nursing Referral For	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 54	F 689		

Therapy Screen, dated 11/27/17, indicated R7 was screened for safety on 11/13/17, due to two falls and self transfers. The Screen indicated R7 was now assist of two staff with hoyer [EZ-Lift] for all transfers in room.

On 10/18/18, at 11:14 a.m. clinical manager (CM)-A stated R7 required maximum assistance with all activities of daily living and was transferred with two staff and mechanical lift at all times. CM-A stated R7 was at risk for falls and her expectation for staff would be to follow R7's care plan and the care guides and to use the mechanical lift for all transfers.

On 10/19/18, at 11:42 a.m. the DON stated R7 required assistance with activities of daily living, was at risk for falls and injuries, and required two staff and mechanical lift for all transfers. The DON stated she was aware R7 was transferred with the EZ-Stand by NA-I. DON indicated she had reviewed the proper use of the EZ-Stand equipment with NA-I last evening after R7's transfers. The DON stated all NAs at the facility would be completing full education on EZ-Stand use.

On 10/19/18, at 1:04 p.m. during a phone interview with EZ-Way product specialist (EWPS)-A stated all EZ-Stand training included placing the EZ-Stand harness under both arms always. She stated the arms always have to be over the harness, or there would be a risk of slipping out of the harness and falling. EWPS-A stated staff should always tighten the harness as the EZ-Stand's arms are raised, as the harness will become looser as the resident stands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 689	Continued From page 55	F 689		

Review of the facility policy titled, Accidents/Falls-HDGR [Health Dimensions Group], last revised 2/14, indicated the facility strived to promote safety by providing interventions to prevent avoidable accidents. The policy indicated the resident's individualized care plan was to be updated with any changes or new interventions post fall, communicated to appropriate staff, and implemented. Post fall incidents would have continued follow-up on the 24 hour report charting for 72 hours so as to continue assessment for possible injuries as well as to further evaluate the interventions put into place.

Review of the facility policy titled, Lift-Sit to Stand, last revised 3/1/14, indicated staff would refer to instructions for the facility equipment to be used. Staff must be trained in lift use and safety precautions. The policy further indicated 1. Obtain correct lift and sling. 8. Transfer according to manufacture direction guidelines.

SMOKING
R40's significant MDS dated 7/10/18, identified R40 had intact cognition, had diagnoses which included major depression, macular degeneration (a condition which causes visual impairment), conversion disorder with seizures or convulsions (a mental condition in which a person has blindness, paralysis, or other nervous system (neurological) symptoms that cannot be explained by medical evaluation).

R40's smoking assessment dated 9/26/18, identified R40 was able to move to and from the designated smoking area with wheelchair, able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 56	F 689		

safely use lighter or matches and safely extinguish cigarette, however; forgets to remove oxygen before going out at times and was observed smoking cigarette in room recently. R40's smoking assessment noted,"Staff remind her to remove O2 (oxygen) prior to smoking at times. Smoking materials to be kept at the nurses station."

R40's care plan revised 10/1/18, identified as a focus: R40 had been assessed to be safe to smoke independently but staff to manage smoking materials due to an incident of smoking in her room. R40 utilized oxygen and was able to remove it independently prior to going outside to smoke. The care plan interventions directed smoking material to be stored at nurses station in the locked medication room. R40 was to ask for a cigarette and lighter from the nurse when desired. Staff to ensure oxygen tank was removed prior to going outside to smoke.

The facility form titled Aid Care Guide dated 9/23/18, identified R40 as a current independent smoker, with smoking materials housed at the nurses station and resident to ask nurse when wanting to go out to smoke.

Review of R40's progress notes from 7/10/18 through 10/12/18 identified:
- 8/3/18, R40 noted to be outside of facility under the front door canopy smoking while oxygen was on.
-9/27/18, the social services designee (SSD) reported R40 found smoking in room.
-9/27/18, A follow up note identified- smoking materials removed from residents room (cigarettes and lighter),- Reviewed smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 57	F 689		

policy- Educated about no smoking in the facility at any time-Explained the nurses are now to house her smoking materials locked at the nurses station-Resident was to request cigarettes and lighter from nurses and they will disperse the items- Oxygen was to be removed by the nurse or R40 prior to going outside to smoke -Lighter was to be returned to the nurse when done smoking.
-9/28/18, Nurse observed R40 clicking lighter in hand while sleeping. Lighter was removed.

An incident report dated 9/27/18, described the incident as follows: Report by SSD, R40 was smoking in her room. R40 admitted to smoking in her room because she thought no one would know. The lighter and cigarettes were taken from R40. No injury noted.

During an interview on 10/15/18, at 11:54 a.m. R40 indicated she was able to smoke independently without restrictions, at the facility designated smoking area outside of the facility.

On 10/17/18, at 2:51 p.m. R40 propelled self with electric wheelchair to R33's room which was empty and then to the dining room. R40 exited the dining room and requested surveyor to come with her outside while she smoked. When R40 reached the front entry door, she removed the oxygen tank from her wheelchair. The director of nursing (DON) asked R40 where she had obtained the smoking materials, to which R40 responded, "from my daughter, so I have my own." The DON explained R40's smoking materials were to be kept by the nurse. R40 became angry and continued outside to smoke. When R40 reached the smoking area outside of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 58	F 689		

the facility R40 reached into her sweatshirt pocket and produced a pack of New Port cigarettes which held 2 cigarettes and a lighter. R40 lit the cigarette and placed the lighter back into the pack and into her sweatshirt pocket.

On 10/18/18, at 9:09 a.m. R40 independently returned from the outside smoking area to the facility with the electric wheelchair. R40 stopped on the left side of the facility office where she had left the oxygen tank. R40 reapplied the oxygen tubing with the nasal cannula in the nose and tubing behind the ears. R40 then placed the oxygen tank on the foot rest between her feet. R40 propelled herself in the electric wheelchair down the hall and directly to her room. R40 did not approach facility staff to return the smoking materials.

On 10/18/18, at 11:00 a.m. R40 independently returned from the outside smoking area to the facility with the electric wheelchair. R40 propelled herself directly to her room and reapplied the oxygen tubing and tank which was left in the room prior to exiting the building to smoke. R40 did not return smoking materials to facility staff.

On 10/18/18, at 11:22 a.m. LPN-B identified she did not work with R40 and did not manage smoking materials for her.

On 10/18/18, at 11:26 a.m. LPN-A verified she stored R40's smoking materials in the medication cart and would give them to R40 when she asked. LPN-A identified R40 had not asked for the smoking materials today. LPN-A looked through he medication cart and was unable to find R40's cigarettes and lighter. LPN-A then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 59	F 689		

looked in the medication room, where only an unopened pack of New Port cigarettes were found on the counter but no lighter. LPN-A indicated R40 typically comes to staff to ask for cigarettes and the lighter but does not return the items causing staff to ask R40 to return them. LPN-A indicated the New Port cigarettes were R40's, however; she was unsure where the lighter was. LPN-A indicated it had been a while since R40 had asked her for smoking materials and verified she had not given R40 cigarettes or a lighter today.

On 10/18/18, at 12:38 p.m. R40 propelled herself from the dining room to the front entry of the facility where she removed her oxygen tubing and tank. R40 propelled the electric wheelchair outside to the designated smoking area. R40 reached into the right pocket of her gray sweatshirt and produced a metal cigarette case and lighter. R40 independently lit the cigarette.

On 10/18/18, at 2:19 p.m. LPN-A identified she was the only staff member during this shift who had access to the R40's smoking materials. R40 had not requested smoking materials today and was not given any. LPN-A indicated she was unaware of the reason R40's smoking materials were managed by nursing. LPN-A stated, "it must be the facility policy."

On 10/18/18, at 2:26 p.m. NA-A identified the nursing assistants did not assist R40 with smoking. NA-A identified R40 was independent to propel herself outside to smoke after the nurse provided her with cigarettes and lighter. NA-A indicated R40 was able to take the pack of cigarettes and lighter and upon return from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 60	F 689		

outside needed to return the smoking materials to the nurse.

On 10/18/18, at 3:47 p.m. Registered nurse (RN)-A indicated R40 independently propelled self out of the building to smoke when R40 chooses. RN-A indicated R40 did not come to RN-A to ask to smoke.

On 10/18/18, at 3:52 p.m. R40 propelled the electric wheel chair to her room. R40 picked up the gray sweat shirt and stated," I was going out and I left all my goodies here (indicating cigarettes and lighter)." R40 picked up the gray sweat shirt and continued outside to the smoking area. R40 stated she is free to go outside and smoke independently, has no restrictions with smoking and doesn't need to tell anyone she is going.

On 10/18/18, at 3:54 p.m. the DON verified R40's smoking assessment dated 9/26/18, and care plan as accurate and current. The DON verified R40 was required to turn in the cigarettes and lighter because R40 was found smoking in her room on 9/27/18, and it was a concern that R40 may try again to smoke in the facility and also with oxygen in the room. The DON indicated the nurse was responsible for R40's smoking materials because the items were locked in the medication cart or room and only the nurse has access to these areas. The DON verified R40 had cigarettes and a lighter in her possession on 10/17/18, which she had not received from the nurse.

On 10/19/18, at 9:04 a.m. the DON stated R40 did have a metal cigarette case and lighter on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 61 person last evening and did give them to nursing with out complaint. On 10/18/18, at 3:44 p.m. NA-C indicated R40 was independent to go outside to the smoking area and smoke independently. NA-C was not aware of any restrictions for R40's smoking. The undated facility policy titled Resident Smoking Policy, identified the Purpose: To provide a safe smoking program that respects the rights and dignity of all Residents.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 62 Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to address unplanned weight loss for 1 of 2 residents (R18) reviewed for nutrition. Findings include: R18's admission Minimum Data Set (MDS) dated 8/23/18, identified R18 had diagnoses which included; dementia, hemiplegia (weakness on one side of the body), and aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write). R18's MDS further identified R18's cognition was severely impaired, required extensive assistance with eating, and identified no rejection of care. R18's MDS also identified no dental issues, no swallowing issues, weight of 167 pounds, mechanically altered diet, and no or unknown weight loss of 5 % (percent) or more in the last month or 10% in the last 6 months. Review of R18's Care Area Assessments (CAA) dated 8/29/18, identified R18 was at risk for a nutritional problem and potential weight loss related to her cognitive impairment, her need for a pureed texture diet and on her dependence on staff to eat. R18's CAA indicated she rarely/never verbalized her needs and was dependent on staff for all activities of daily living (ADL) due to her cognitive impairment and deficits from her stroke years ago. The CAA further identified, R18 had limited understanding of others and would have physical behaviors during cares and verbal behaviors of yelling out during cares as she did not understand, and staff may have to re-approach. The CAA indicated these behaviors	F 692	o R18 has been comprehensively assessed and interventions in place to address weight loss o All other residents with unplanned weight loss will be reviewed and interventions determined to address weight loss o Education will be provided to IDT and licensed nurses on tracking weights and comprehensive assessment and interventions needed to address unplanned weight loss o Audit of residents with unplanned weight loss to assure appropriate interventions are in place will be done two times weekly for four weeks and then weekly for four weeks and monthly for two months. o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date 11/28/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 692	Continued From page 63	F 692		

usually do not happen when staff assist her to eat. R18's CAA indicated her weight had been stable since admission and her meal intakes fluctuate, ranging from 25 to 100%. The CAA indicated R18's goal was to maintain her current weight and nutritional status with no significant weight loss.

R18's care plan, last revised 10/19/18, identified R18 had the potential for decline in nutritional status related to dementia, aphasia, hemiplegia, dysarthria (condition in which the muscles you use for speech are weak or you have difficulty controlling them), need for pureed textures, and dependence on staff for eating/drinking. R18's care plan listed various interventions which included; occupational therapy or speech language pathology as ordered, regular diet with pureed textures and thin liquids, observe for signs and symptoms of dehydration, encourage fluid intake with meals and between, provide fluids per her preference, and provide water with meals and between.

R18's Aide Care Guide Group B, dated 9/23/18, identified R18 required extensive assistance from one to two staff and was on a pureed texture diet.

On 10/16/18, at 9:44 a.m. R18 was observed seated in a wheelchair in her room with eyes opened. Family member (FM)-A stated R18 does not eat much at meals. FM-A indicated he visited daily and assisted R18 to eat some of her meals.

On 10/17/18, at 5:20 p.m. R18 was seated in her reclined wheelchair at the dining room table. A dietary staff member approached R18 with two glasses of liquids, which were placed on the table

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 692	Continued From page 64	F 692		

in front of her. At 5:21 p.m. FM-A entered the dining room and approached the back of R18's wheelchair. FM-A used the controls on the wheelchair to assist R18 into an upright seated position at the table. FM-A then sat down in a chair beside R18 and talked. At 5:39 p.m. FM-A assisted R18 with sips of juice out of a standard cup. At 5:44 p.m. R18 and FM-A were both served a supper meal. FM-A assisted R18 with bites of pureed food and alternated with drinks of fluids. In between R18's bites of food FM-A would sit down and take bites of his own meal. At 5:55 p.m. he offered R18 a bite of food and she shouted "no". FM-A then tried a drink and R18 closed her lips tightly. FM-A then sat down and continued with his meal. At 6:00 p.m. FM-A finished his meal and asked staff seated at the table assisting another resident to eat, if they were going to help R18 eat. The unidentified staff member stated they would assist R18 when they were done assisting the resident they were already helping. FM-A then left the dining room. At 6:05 p.m. R18 continued to be seated in the wheelchair at the dining room table. R18 had begun holding her face with her left hand. At 6:10 p.m. R18 remained in the same position with face in her left hand as her supper meal of fruit, carrots, rice and chicken remained siting in front of her. At 6:12 p.m. the unidentified staff member approached R18 and encouraged her to eat some fruit. R18 did take a few more bites of fruit. At 6:17 p.m. R18 refused to eat any more by stating "no" again, and staff assisted to wipe her face. R18 had consumed approximately 25% of the supper meal.

On 10/18/18, at 11:57 a.m. R18 was seated in her wheelchair at the dining room table. Dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 692	Continued From page 65 staff brought R18 and FM-A lunch which consisted of mashed potatoes, meatballs and brussel sprouts. FM-A assisted R18 with four bites of the lunch meal when R18 yelled out "ow, ow". FM-A stopped attempting to assist R18 with her meal, turned her around in her wheelchair and pushed her wheelchair out of the dining room. At 12:40 p.m. R18's lunch remained at the dining room table. Review of R18's weight record from the electronic health record (EHR) from 8/17/18, to 10/12/18, revealed: -8/17/18, 164.6 -8/20/18, 167.4 -8/24/18, 166.1 -8/31/18, 166.4 -9/8/18, 167.1 -9/14/18, 167.0 -9/16/18, 167.0 -9/21/18, 165.7 -9/28/18,160.7 -10/5/18, 156.8 : R18's EHR showed a warning of a 5% weight change "[Comparison Weight 09/08/2018, 167.1 lbs [pounds], - [negative] 6.2%, -10.3 pounds]" -10/12/18, 155.9 : R18's EHR showed a warning	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 692	Continued From page 66 of a 5% weight change "[Comparison Weight 09/14/2018, 167.0 lbs, - 6.6%, -11.1 pounds]" Review of R18's signed physician orders dated 9/5/18, indicated R18 had a pureed diet with thin liquids. However, after further review R18's orders had no orders to receive a dietary supplement. Review of R18's electronic record indicated in the last 30 days R18's meal intakes varied from 0-100%, she received total assistance for eating, and had accepted four bedtime snacks. Review of R18's Dietary Profile HDG [Health Dimensions Group], dated 8/22/18, indicated R18 was on a regular, pureed diet and regular liquids. The assessment indicated R18 was not on a fluid restriction, did not receive a nutrition supplement prior to admission, and did not receive a nutritional supplement currently. The assessment further indicated, R18 had regular portions, a fair appetite and drank four cups of fluids per day. Under the Likes and Dislikes text box only a dash was noted. R18 had good hearing and sight, was alert, did not have own teeth, did not indicate if a denture was worn, but had no chewing or swallowing problems. The assessment also indicated R18 used regular utensils, did not use adaptive equipment, and required total assistance. The assessment concluded with a comments text box which indicated R18 was hard to communicate other then yes or no questions and a family member often sat with her. On 10/18/18, at 2:16 p.m. nursing assistant (NA)-J stated R18 was a total assist with all	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 692	Continued From page 67	F 692		

cares. She indicated R18's appetite depended on her mood and if staff get her started with the meal right away she does well. NA-J stated if R18 did well eating at breakfast, she would not each much at lunch. NA-J stated FM-A would sit with R18 often and would assist her to eat once in a while. She stated FM-A took R18 away from the dining room early today due to wanting to go for a car ride. NA-J stated if R18 did not eat well at a meal, then staff would try a pudding cup later after the meal. NA-J stated there was no place to document the pudding. She indicated R18 was weighed weekly by the NAs, and the NAs would document the weights in a binder and if the weight seemed off staff were to reweigh the resident.

On 10/18/18, at 2:26 p.m. licensed practical nurse (LPN)-A stated R18 required total assist for all cares, including eating. LPN-A indicated R18's appetite had been okay and someday's she did not feel like eating. LPN-A stated if R18 did not eat well at a meal staff try to encourage her a little, and then let her rest. She stated the nurses should know about low meal intakes, but stated the NAs don't always tell us. LPN-A identified some residents on nutritional supplements, but confirmed R18 was not currently receiving a supplement. She stated R18 was weighed weekly on Fridays by the NAs, whom place the weight in a binder and the nurse would chart it in the EHR. LPN-A stated she did not review weights in the EHR and added it must be done by the upper management. She stated FM-A assisted R18 to eat at times, but got frustrated easily and will leave, then staff would take over.

Review of Weights B Group form, dated 8/27/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 68	F 692		

through 10/14/18, indicated "Nurses-Please reweigh if wt [weight] is [up or down] 5 #[pounds] or more. Report to Dietary Manager if continues". R18's weight on 9/21/18, was 165.7 pounds and on 9/28/18, was 160.7 pounds, however no reweigh was identified.

On 10/18/18, at 2:55 p.m. clinical manager (CM)-A indicated the nurses would chart the weights from the NA binder into the EHR and would look back to see if there were any concerns for changes and update the physician, CM-A, or the director of nursing (DON). CM-A stated the facility had a consultant dietician (CD) that came to the facility monthly. CM-A indicated the CD would be updated if the facility noted a significant weight loss or swallowing problem. CM-A reviewed R18's weights since admission and stated she had lost 9 pounds. CM-A reviewed R18's clinical record and confirmed R18 was not on a nutritional supplement, and R18's record lacked a dietician note or assessment. CM-A stated the facility would update the CD when a 5% weight change was noted and indicated the CD was last at the facility two weeks prior.

On 10/19/18, at 9:16 a.m. during a phone interview CD-A stated she was the CD for the facility and her usual process would be to come to the facility monthly, and would be updated between visits via email or phone calls. CD-A stated she reviewed all residents annually, and anyone else the facility wanted her to assess, which included residents on tube feedings, those with stage III pressure ulcers or higher, or significant weight loss of 5% or more in 30 days, or 10% in 180 days. CD-A stated she would get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(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 692	Continued From page 69	F 692		

email updates from CM-A, DON, or the dietary manager (DM)-A. CD-A indicated she was unaware how the facility reviewed or tracked resident weights. CD-A stated the DM would complete the residents' quarterly assessments. CD-A stated R18's body max index (BMI) was over 24.9, so would be less concerned, but would expect an assessment to be completed to see what was going on with R18.

On 10/19/18, at 9:38 a.m. NA-K stated R18's appetite was not good, and took a lot of encouragement to eat and added R18 never eats anything. NA-K indicated at times if staff started with something sweet her intake would be better.

On 10/19/18, at 9:50 a.m. DM-A stated dietary staff charted the meal intakes, and nursing would chart the resident weights. DM-A indicated she did not review resident intakes or weights at this time and was something her and the DON were meeting on to discuss weights and nutritional supplements. DM-A indicated nursing staff would be reviewing residents for weight loss. DM-A stated R18's only dietary assessment was on admission and indicated the assessment was to gather information for R18's MDS. DM-A stated CM-A used to be the one to look at between MDS assessment nutritional needs, but CM-A was transitioning roles. DM-A stated she was not aware of R18's weight loss.

On 10/19/18, at 11:27 a.m. the DON stated nurses were to review the resident weights when entering into the EHR and should be alerting CM-A, MDS coordinator, or the DON if a significant weight loss was noted. DON stated a significant weight loss would be 5 pounds in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 692	Continued From page 70	F 692		

week. The DON indicated CM-A was in the process of reviewing R18's weights and were going to start some nutritional supplements. The DON stated R18's intakes have been up and down, and FM-A will sometimes just say that is enough and R18 will quit eating. The DON stated staff should have alerted CM-A on R18's weight loss after the 9/21/18, to 9/28/18, weight loss, so CM-A could have alerted the CD. The DON stated her expectation for staff was to follow the directions on the Weights B Group form which instructed the nurse to reweigh if a five pound weight loss and report to the DM.

Review of the facility policy titled Nutrition, dated 4/1/08, indicated the facility maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this was not possible.

The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section K: Swallowing/Nutritional Status to be completed with an intent to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. Under K0300: Weight Loss Planning for Care:

"-Weight loss may be an important indicator of a change in the resident' s health status or environment.

-If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need,

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F 692	Continued From page 71 change in medication (e.g., diuretics), or changed fluid volume status. - Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment."	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide safe tracheotomy suctioning (surgical opening through the neck into the trachea (windpipe) to allow direct access to the breathing tube) for 1 of 1 residents (R10) observed during tracheostomy suctioning while requiring mechanical ventilation (life support system designed to replace normal ventilatory lung function). Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/2/18, identified R10 was cognitively intact, required total assistance with activities of daily living (ADL) and was able to use his electric wheelchair independently with supervision.	F 695	o R10 has been provided tracheostomy suctioning according to standard of practice o All other residents needing tracheostomy suctioning will be assessed for safe suctioning o Education provided to licensed nurses on proper procedure for safe tracheostomy suctioning o Audits for assessment of tracheostomy suctioning will be done two times per week for four weeks and then weekly for one month and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as	11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 695	Continued From page 72 R10's MDS also identified diagnoses which included cerebral palsy (permanent movement disorder that usually appeared in early childhood) anxiety and respiratory failure. R10's MDS further identified he used oxygen, required suctioning, tracheostomy care and ventilation. R10's care plan last reviewed 8/7/18, identified ventilator dependent and tracheostomy due to chronic respiratory failure with hypoxia (condition which the body or region of the body is deprived of oxygen). R10's care plan further indicated to suction tracheostomy PRN (as needed) and at least 1 time per shift. On 10/17/18, at 2:36 p.m. R10 was lying in bed, with the head of bed slightly elevated. Registered nurse (RN)-A was in the room, getting supplies ready for suctioning. RN-A began looking for the suction kit, when R10 informed her they were in the top drawer of the bed side table. R10 indicated to RN-A he could tell her how to perform the suctioning. RN-A placed the suction kit on the bedside table and began to prepare for suctioning. R10's ventilator alarm sounded, and he said it would stop once the suctioning was completed. RN-A opened R10's cap on his tracheostomy ventilator tube and completed one suctioning. R10 told RN-A to close the cap when she was done. RN-A did not close the cap, but proceeded to dip the end of the suctioning catheter tube into the sterile water to cleanse the suction catheter, then began to suction R10 a second time. R10's face became very red in color during the second suctioning procedure. RN-A then closed the cap on the tubing which allowed R10 to resume breathing with the assistance of the ventilator. RN-A asked if he	F 695	needed. o Compliance date 11/28/2018	

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F 695	Continued From page 73	F 695		

wanted to be suctioned again, and he informed her two times he was good. R10 then reminded RN-A to close the cap between suctioning. RN-A indicated that she did not need to close the cap between suctioning with another resident. R10 indicated yes that may be, but informed RN-A he was dependent on his ventilator.

On 10/17/18, at 6:59 p.m. RN-A indicated she had received training by observing another nurse complete suctioning, then she was observed while completing suctioning. RN-A indicated while she cleansed the catheter, she should have closed the cap to allow R10 to catch his breath before she repeated the suctioning.

On 10/18/18, at 2:14 p.m. licensed practical nurse (LPN)-A indicated when she completed R10's suctioning, she would close the cap between suctioning so he could get his air, and breath. LPN-A indicated if she completed suctioning two or more times for R10, she closed the cap in between suctioning so he could rest.

On 10/19/18, at 9:51 a.m. clinical manager (CM)-A indicated she performed training on ventilation machines for the licensed nurses when they were hired. CM-A indicated the nurses orientated new nurses on suctioning techniques. CM-A indicated North West Respiratory company completed training for the licensed nurses annually on the ventilators and suctioning also. CM-A indicated if a resident required suctioning more than once, the nurses were to close the cap on the resident's tubing, to allow for the ventilator to be on so the resident could have a couple of breaths before suctioning again. CM-A confirmed R10 was dependent on

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F 695	Continued From page 74 his ventilator and she would expect the licensed nurses to give him a break between suctioning by closing the cap and allowing the ventilator to be working. CM-A indicated R10's face would turn red when coughing or having spasms. On 10/19/18, at 10:15 a.m. director of nursing (DON) indicated CM-A provided the suctioning training for the licensed nursing staff, and if there were concerns she would have to defer to CM-A regarding concerns and technique and review the policy. RN-A's training provided included the forms titled Policy and training for Nursing assistants on Caring for Residents on Ventilators and Mechanical Ventilation Management Protocol Policy and procedure, both signed 10/10/18 by RN-A and trainer. Training listed included suctioning needs. The facility policy titled Tracheotomy Suctioning dated 12/23/13, identified the purpose was to ensure and maintain a patent airway for patients with tracheotomy and help prevent infection. The procedures included to withdraw the catheter, review resident is comfortable and then to complete suctioning steps listed again.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 726		11/28/18

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F 726	Continued From page 75 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all nursing staff possessed necessary competencies and skill sets to meet resident mechanical transfer needs for 1 of 2 (R7) residents reviewed for accidents. Findings include: Review of R7's quarterly MDS, dated 7/25/18, identified R7 had moderately impaired cognition, and had diagnoses which included palliative care (managing the symptoms and side-effects of	F 726	o R7 has been transferred with total lift in accordance with plan of care o All residents care guides reviewed to ensure proper lift is reflected for safe transfer o Nursing staff educated on following what care guide designates for safe transfers o Nursing staff educated with return demonstration on proper use of the lift machines o Audit of proper use of mechanical lift to be completed two times weekly for four	

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F 726	Continued From page 76 life-limiting and chronic illness), hemiparesis, schizophrenia, and Diabetes Mellitus. The MDS indicated R7 required total assistance for transfers with two or more staff. The MDS further indicated R7 had two or more falls since the last assessment. Review of R7's Care Area Assessments (CAA), dated 5/9/18, identified R7 displayed poor judgement and safety awareness with poor decision making as evidenced by attempts to self transfer, which resulted in falls. The CAA indicated R7 believed he could stand and attempted to do so in order to self transfer from the wheelchair to bed. The CAA also indicated, R7 had a history of a stroke which resulted in right sided hemiparesis, was unable to walk or stand, was a fall risk, and required a full body lift for transfers. Review of R7's care plan, last revised 10/5/18, indicated R7 was at risk for falls related to a history of falls due to self transfer attempts, as R7 believed he could still stand and walk, incontinence, balance issues, and right sided hemiparesis. R7's care plan listed various interventions which included a low bed, physical therapy to assess for proper wheelchair fitting status post fall, and mechanical lift to transfer with total assist of two staff. Review of Aide Care Guide Group B, dated 9/23/18, indicated R7 used a wheelchair, had a high-low bed, required extensive assistance with activities of daily living and transferred with total assist of two staff and a mechanical lift. On 10/17/18, at 2:23 p.m. R7 was seated at the	F 726	weeks for 3 residents and then weekly for one month and monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 11/28/2018	

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F 726	Continued From page 77	F 726		

edge of bed with the bed approximately at knee height. R7 had an EZ-Way Stand (mechanical standing transfer equipment) positioned directly in front of him. R7 had a beige (medium) colored harness around his back, which was attached to the EZ-Way Stand's hydraulic arms. NA-I stood behind the machine's controls and attempted to raise the hydraulic arms, but the machine did not move. NA-I stated the battery had died, she removed the battery and left the room with R7 sitting at the edge of the bed, with harness behind him and feet on the stand's foot plate. As NA-I retrieved a different battery, R7 stated he used this machine often. At 2:25 p.m. NA-I returned to R7's room and placed a different battery. At 2:26 p.m. NA-I raised the arms of the machine which assisted R7 to a semi-standing position. R7 held onto the machine's hand grips with his left hand, as he was unable to hold on to the machine with his right hand. The EZ-Stand's harness was under R7's left arm, but R7's right elbow rested on the middle of the harness on the right. The harness buckle was closed loosely around R7's waist. As R7 was raised by the standing machine, NA-I stood behind the machine and did not attempt to tighten the harness's buckled strap, around R7's waist. NA-I then moved the EZ-Stand, with R7 holding on to the machine with one hand and his right elbow pushing against the harness on his right, towards R7's bathroom. NA-I stopped before R7's bathroom, removed R7's pants and an incontinent brief, and pushed R7 and the machine into the bathroom. NA-I then pushed R7 into the bathroom. As R7's buttocks neared the toilet, NA-I had to raise R7 higher in the EZ-Stand to get his buttocks over the arm rest of the toilet. R7 remained holding onto the machine

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F 726	Continued From page 78	F 726		

with only his left hand and his elbow rested in the harness. NA-I then lowered R7 onto the toilet and left him attached to the EZ-Stand machine and left the bathroom. At 2:29 p.m. NA-I stated she worked for a nursing agency, and had worked at the facility for two months. At 2:32 p.m. R7 stated he was done using the toilet and NA-I entered R7's bathroom. NA-I used the machine's controls and raised R7 to a semi-standing position. NA-I completed perineal cares and pulled the EZ-Stand machine, with R7, out of R7's bathroom. As NA-I maneuvered the EZ-Stand towards a bath chair, the harness around R7 began sliding up his back. R7's right elbow remained positioned on the harness, with his right hand pulled closely to his chest. The harness buckle had moved up from his lower abdomen to his upper chest and R7's right foot was positioned off of the foot plate. At 2:34 p.m. NA-I lowered R7 onto a bath chair. When R7 was seated in the bath chair, the lower border of the EZ-Stand harness was around R7's upper back, with the upper border of the harness at R7's upper neck. Near R7, in the bath chair, was R7's wheelchair. In the seat of the R7's wheelchair was a sling for the EZ-Lift (mechanical lifting transfer equipment) machine. At 2:37 p.m. NA-I removed the rest of R7's clothing and placed a bath robe on R7 and pushed the bath chair from R7's room to the tub room.

On 10/17/18, at 2:57 p.m. R7 was seated in the bath chair, covered in the bath robe, back in his room after a bath. The EZ-Stand machine was again positioned in front of him. At 2:59 p.m. NA-I picked up the beige EZ-Stand harness and placed it behind R7 in the same position as above, except positioned the right side of the

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 726	Continued From page 79	F 726		

harness onto R7's right elbow, which was inside the bathrobe's sleeve. NA-I buckled the harness around R7's abdomen and pulled the buckle strap tighter. NA-I placed R7's feet onto the foot plate and applied the calf strap, then used the controls to raise the EZ-Stand's hydraulic arms. R7 stood up, while holding onto the machine's hand grips using his left hand, as his right hand was inside the bathrobe. As the machine assisted R7 to a standing position, the harness buckle strap became looser, and NA-I did not attempt to pull the buckle's strap tighter. At 3:05 p.m. R7 was lowered by the machine onto the edge of the bed. NA-I removed the machine's harness and assisted R7 to lay flat and assisted R7 to dress. At 3:09 p.m. NA-I pushed R7's wheelchair near the bed and locked the wheels. NA-I then picks up an EZ-Lift sling that was on the wheelchair's seat and placed the sling on a stand near the bed. At 3:10 p.m. NA-I moved the EZ-Stand machine to the side of R7's bed near the bed rail. NA-I tried to assist R7 to sit up at the edge of the bed, but R7 was unable to assist in the bed mobility. NA-I then placed a transfer belt on R7 and raised the head of R7's bed. NA-I then grabbed around R7's upper back with the right arm and held onto the transfer belt with the left arm and tried to assist R7 to an upright seated position at the side of the bed. R7's right side remained slumped back and leaned to the left. NA-I placed the EZ-Stand harness around R7's back, while holding R7 in a seated position utilizing the transfer belt. At 3:14 p.m. R7 stated "I'm not sitting right" as NA-I struggled to place the machine's harness. At 3:16 p.m. NA-I attached the harness to the EZ-Stand machine and stated "you are not seated well", and gave R7 instructions to hold onto the machines handle.

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F 726	Continued From page 80 At 3:18 p.m. NA-I started to raise the EZ-Stands mechanical arm, attempting to assist R7 to sit straight in front of the machine. At 3:20 p.m. NA-H knocked and entered R7's room. NA-H stated to NA-I "we can lay him down and use the hoyer [EZ-Lift], since he is tired". At 3:22 p.m. NA-H asked R7 if he preferred to lay in bed and nap and R7 answered "yes". NA-I and NA-H removed the EZ-Stand harness and assisted R7 to lay down, and the two staff boosted R7 up in bed, lowered the bed and left the room. On 10/17/18, at 7:27 p.m. NA-I stated R7 required extensive assistance with cares and was a fall risk. NA-I stated when R7 wanted to do something, like go to bed, you have to be quick as he would try to do things on his own. NA-I stated R7 transferred mostly with two staff and the EZ-Lift, but at times used the EZ-Stand. NA-I stated she used the EZ-Stand with R7 at least once a shift, as she could use the standing transfer equipment with only one staff present. NA-I stated R7 struggled with the EZ-Stand today, and if the transfer does not go well with the Stand we would use the Lift. NA-I stated it was good for R7 to use the standing transfer machine as he would get to exercise his legs, and when he used the Lift his legs just lay there in the air. NA-I indicated R7's care plan would instruct how to transfer R7, or the care guide. NA-I checked for the care guide and could not find one. At 7:36 p.m. NA-I found her care guide at the nurse's station and confirmed R7 was to be transferred with two staff and the hoyer [EZ-Stand]. NA-I indicated when she started at the facility other NAs showed her the EZ-Way machines, and she had used the EZ-Way machines at a facility in the past. NA-I indicated	F 726		

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 726	Continued From page 81 she was not aware if a competency check was completed on the facility's EZ-Way Lift or Stand. Review of the facility provided EZ-Way, Inc. EZ Way Stand Operator's Instructions, undated, indicated "Transferring the patient: Attach harness 1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2-3 inches below the underarm. 20 For the safety of the patient, securely fasten the safety strap around the patient's torso. 3) Secure the buckle and pull the strap to tighten. ... Raise the patient 1) Position patient's arms on the outside of the harness and have them place their hands on the padded handles. 2) With hand control in-hand stand beside the patient. ....Press the up button. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso." On 10/18/18, at 9:40 a.m. PT-A stated a harness placement that was not under both arms, or having one arm under clothing while transferring a resident would not be safe. At 10:14 a.m. PT-A confirmed R7's last safety screen with transfers was 11/17, and therapy's recommendation would be to continue to use EZ-Lift and two staff for all transfers. Review of Pro Rehab Nursing Referral For Therapy Screen, dated 11/27/17, indicated R7 was screened for safety on 11/13/17, due to two falls and self transfers. The Screen indicated R7 was now assist of two staff with hoyer [EZ-Lift] for all transfers in room. On 10/18/18, at 11:14 a.m. clinical manager	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 726	Continued From page 82	F 726		

(CM)-A stated R7 required maximum assistance with all activities of daily living and was transferred with two staff and mechanical lift at all times. CM-A stated R7 was at risk for falls and her expectation for staff would be to follow R7's care plan and the care guides and to use the mechanical lift for all transfers.

On 10/19/18, at 11:42 a.m. the DON stated R7 required assistance with activities of daily living, was at risk for falls and injuries, and required two staff and mechanical lift for all transfers. The DON stated she was aware R7 was transferred with the EZ-Stand by NA-I. DON indicated she had reviewed the proper use of the EZ-Stand equipment with NA-I last evening after R7's transfer. The DON stated all NAs at the facility would be completing full education on EZ-Stand use.

On 10/19/18, at 1:04 p.m. during a phone interview with EZ-Way product specialist (EWPS)-A stated all EZ-Stand training included placing the EZ-Stand harness under both arms always. She stated the arms always have to be over the harness, or there would be a risk of slipping out of the harness and falling. EWPS-A stated staff should always tighten the harness as the EZ-Stand's arms are raised, as the harness will become looser as the resident stands.

On 10/19/18, at 1:16 p.m. during a follow up interview with the DON, the DON stated she assumed training with the EZ-Way machines was completed on the floor with a checklist. She indicated the operations manager (OM)-A completed new hire classroom orientation, and CM-A completed floor training after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 726	Continued From page 83	F 726		

classroom was completed. The DON indicated she was unaware what orientation the nursing agency staff received. Her expectation would be, if the facility would not have evidence of the nursing agency staff member's competency training, she would expect the facility would complete competency training. The DON stated the facility goes with what areas the nursing agency stated their staff were competent in.

On 10/19/18, at 1:20 p.m. OM-A stated she completed the all staff new employee general orientation and CM-A completed further training for nursing staff. OM-A stated she completed no training for EZ-Way Lift or Stand.

On 10/19/18, at 1:26 p.m. CM-A indicated the new employee training included the topics of infection control, proper body mechanics and Tuberculosis (a contagious infection caused by bacteria that mainly affects the lungs but also can affect any other organ). CM-A stated new staff are trained on the EZ-Way machines when they are orientated to the floor, and this was completed by other nursing staff which already work on the floor. CM-A stated no competency checks were completed on staff after the peer education received on the nursing floor. CM-A indicated the EZ-Way representative comes to the facility from time to time to re-educate on the machines, but could not recall the last time the representative was at the facility. CM-A stated OM-A may have new nursing agency staff watch the EZ-Way instruction video, but was not sure. CM-A indicated new nursing agency staff clinical training was focused around tracheotomy (a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 726	Continued From page 84 most often placed through this opening to provide an airway and to remove secretions from the lungs) and ventilators (a machine designed to mechanically move breathable air into and out of the lungs, to provide the mechanism of breathing for a patient who is physically unable to breathe, or breathing insufficiently). CM-A indicated new nursing agency staff would be trained on the EZ-Way machines by their peers on the floor. CM-A stated the facility used to utilize train the trainer (a training strategy were the trainer, a subject-matter expert, trained other employees), but no longer have that process in place. Review of the facility provided Agency Employee Orientation Checklist, dated 8/21/18, indicated NA-I was oriented to various topics which included: Human Resources and Pre-Arrival including competencies and skills testing, On-Boarding, Safety, and Scheduling. On 10/19/18, at 1:22 p.m. NA-I's Agency Competencies and Skills testing was requested, however was not provided. Review of the facility policy titled, Lift-Sit to Stand, last revised 3/1/14, indicated staff would refer to instructions for the facility equipment to be used. Staff must be trained in lift use and safety precautions. The policy further indicated 1. Obtain correct lift and sling. 8. Transfer according to manufacture direction guidelines.	F 726		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 791	Continued From page 85 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	F 791		

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 791	Continued From page 86 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide arrangements for dental care for 1 of 1 residents (R28) reviewed for dental services. Findings include: R28's quarterly Minimum Data Set (MDS) dated 9/19/18, identified R28 was cognitively intact and had diagnoses which included paraplegia (impairment in motor or sensory function of the lower extremities), muscle weakness and limitations of activities due to disability. The MDS identified R28 required assistance with personal hygiene. R28's MDS further identified no dental concerns. R28's care plan revised 9/25/18, indicated R28 had an activities of daily living (ADL) self care performance deficit related to her impaired balance and limited mobility. R28's care plan further indicated she had her own teeth and was independent with oral cares after set up. On 10/15/18, at 9:19 a.m. R28 indicated she needed to see a dentist. R28 indicated they had spoken to her about seeing a dentist at the facility, and once notified her while she was in the bathroom the dentist had come to the facility, but had not been seen by the dentist. R28's admission assessment dated 3/26/18, identified R28 had her own teeth. Review of R28's care conference notes identified the following:	F 791	o R28 has been offered dental appointment 10/19/2018 and declined. She was offered again on 10/31/2018 and declined. o All other residents reviewed to determine dental needs and follow up completed as indicated. o Education provided to nursing staff and IDT on reporting and following up on assistance needed to facilitate dental appointments. o Audit will be conducted two times weekly for four weeks on 2 residents and then weekly for one month and monthly for two months to monitor compliance with dental appointments. o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date. 11/28/2018	

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 791	Continued From page 87 -4/10/18, concerns: teeth/dental- due for cleaning, has partial plate, does not always wear. Form indicated R28 attended the meeting. -6/26/18, concerns: teeth/dental-blank, form indicated R28 attended the meeting. No reference to dental appointment included. -9/25/18, documentation indicated R28 was invited to meeting, but refused. No reference to dental appointment included. There was no indication R28 had seen a dentist, even though the 4/10/18 note identified R28 was due for a cleaning. On 10/18/18, at 9:53 a.m. licensed practical nurse (LPN)-B indicated R28 was cognitively intact and could inform you if she wanted something. LPN-B indicated R28 had never asked her about dental appointments. On 10/19/18, at 8:57 a.m. R28 indicated when she arrived she informed the facility staff she was due for a dental cleaning. R28 stated she would still like to see a dentist, and no one had spoken to her about setting up a dental appointment or transportation. On 10/19/18, at 9:56 a.m. clinical manager (CM)-A indicated she was not aware R28 requested to see a dentist. CM-A confirmed dental exams were discussed at resident care conferences. CM-A indicated the usual facility practice was for the facility to set up dental appointments and transportation. CM-A indicated she would ask residents or responsible parties if	F 791		

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F 791	Continued From page 88	F 791		

a dental exam was needed or wanted and try to arrange the appointment and transportation if needed.

On 10/19/18, at 10:42 a.m. director of nursing (DON) indicated the facility's usual practice for dental exams was the residents were asked on admission if they wanted to see a dentist, or had any concerns. DON indicated they would then assist the resident to schedule the exam if they had a regular dentist, or could be screened by Apple Tree Dental at the facility. DON indicated Apple Tree Dental came into the facility routinely and would screen residents. DON indicated the floor staff could assist in scheduling exams and transportation, or they could inform herself or CM-A who could assist in arranging the dental appointments and transportation. DON indicated her expectations would be for a resident to to added to the Apple Tree Dental list or assisted in a dental appointment if requested or needed.

On 10/19/18, at 12:36 p.m. CM-A indicated she had just followed up with R28 regarding a dental exam. CM-A confirmed R28 still wanted a dental appointment. CM-A indicated R28 informed her she would arrange her appointment herself after she felt better, and asked the facility to arrange for transportation.

The facility policy titled Dental Services (General) -HDGR (Health Dimensions Group) revised 9/22/17, identified the community (facility) would provide or obtain routine and emergency dental services to meet the needs of each resident. The policy further indicated the community would assist the resident in making appointments by arranging transportation to and from the dentist's

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F 791	Continued From page 89 office.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a clean and sanitary kitchen environment and failed to ensure food were properly stored and dated for 1 of 1 walk in cooler/freezer. Furthermore, the facility failed to prepare food in a sanitary manner in 1 of 1 kitchens observed when staff did not utilize hairnets when walking through the preparation area. This had the potential to affect 39 of the 39 residents that received food from the kitchen. Findings include:	F 812	o Coffee maker cleaned and descaled o Food in walk-in cooler and dessert freezer found to not be dated or covered have been disposed of o Kitchen staff have been wearing hair nets o White fan has been cleaned and debris moved o Sink next to juice machine, three compartment sink, and ice machine have been cleaned and de-limed o All food has been reviewed and dated	11/28/18

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 812	Continued From page 90 On 10/15/18 at 7:01 a.m. during an initial tour of the facility kitchen area with cook (C)-A the following concerns were identified: - the coffee maker in the kitchen area, had encrusted hard water lime scale build up with small flakes under the three coffee dispensers. Walk in cooler: - a large bag of shredded lettuce, which was opened and three quarter full was not dated. - a large bag of shredded cheese, which was opened and three quarter full was not dated. - a large block of American cheese, which was opened and half used was not dated. - a large block of white cheese, which was opened and half used was not dated. - a large loaf a banana bread, which was opened and over half used was not dated. - a half of a pan of coffee cake not covered and dated. Dessert freezer: - a large loaf of banana bread that was not dated. - a package of strawberry strudel was opened and noted dated. - a package of cookie doe was opened and not dated. C-A confirmed the above finding and indicated all food items should be properly covered, dated and that this was not normal practice. On 10/15/18 at 7:19 a.m. during observation of food preparation for breakfast with C-A. The dietary manager (DM) entered the kitchen area from the back door by the dry storage area, wearing her coat, purse in hand and proceeded to walk threw the entire kitchen prepping area	F 812	if unopened o Deep clean of food storage and prep area has been completed o Education given to dietary staff on following cleaning schedule o Educated on use of hair nets in entire kitchen area o Audits of dates on food will occur two times weekly for 4 weeks then weekly for one month and then monthly for 2 months to ensure compliance with this practice. o Audits of cleaning schedule occur two times weekly for 4 weeks then weekly for one month and then monthly for 2 months to ensure compliance with this practice. o Audits of use of hair nets will be done two times weekly for four weeks and then weekly for one month and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date. 11/28/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 91 where C-A was prepping sausage for the breakfast meal and other dietary staff was prepping desserts for lunch. DM-A had long brown hair and was not wearing a hair net when she entered the kitchen area where food was being prepped for the day. DM-A confirmed she was not wearing a hair net while walking through the kitchen area while food was being prepped for the day and indicated that she usually does put a hair net on right away when she gets here. DM proceeded to apply a hair net to her long brown hair while she stood in the kitchen area and off to the side of the kitchen area. The DM confirmed staff should wear hair nets at all times when in the kitchen area. At 8:09 a.m. during observations of taking temperatures of food items. A white fan was blowing above the dishwasher and above the clean dish area. The fan had black dust particles on the entire front of it with pieces of long lint/dirt blowing away from the fan and into the air. -at 8:34 a.m. the little sink next to the juice machine in the dining room area of the facility had encrusted hard water lime scale build up with flakes around the faucet, the handles of the sink, and around the entire outer edge of the sink. On 10/19/18 at 9:15 a.m. during a tour of the kitchen with the DM-A the following concerns were identified: - the little sink next to the juice machine in the dining room area of the facility had encrusted hard water lime scale build up with flakes around the faucet, the handles of the sink, and around the entire outer edge of the sink. The DM-A indicated all staff use the sink to wash their hands and was not sure who was responsible for	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 92 cleaning and de-liming the sink. - a white fan was blowing above the dishwasher and above the clean dish area. The fan had black dust particles on the entire front of it with pieces of long lint/dirt blowing away from the fan and into the air. - three compartment sink in the kitchen are had encrusted hard water lime scale build up with flakes around the faucet, the handles of the sink, the sink compartments and around the entire outer edge of the sink. - the ice machine located in the kitchen area had encrusted hard water lime scale build up on the upper lip on the outside of the ice machine lid. - dessert freezer had a large loaf of banana bread that was not dated and a package of strawberry strudel was opened and noted dated. - a large tub of brown sugar half full in a dry storage bin was opened and not dated. - a large tub of powder sugar half full in a dry storage bin was opened and not dated. - a large tub of powdered milk half full in a dry storage bin was opened and not dated. - the air conditioner in the window near the prepping area was blowing and had black dust particles on the entire front of it with pieces of long lint/dirt blowing away from the air conditioner and into the air. - the coffee maker in the kitchen area, had encrusted hard water lime scale build up with small flakes under the three coffee dispensers. The DM-A confirmed the above findings and indicated everything should be labeled and dated when opened. The DM-A indicated the dispensers of the coffee machine was to be cleaned weekly, the sinks should be cleaned daily and the fans cleaned weekly. The DM also	F 812		

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	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 93 indicated they needed to do a better job with de-liming the sinks and ice machine. On 10/19/18 at 10:01 a.m. the maintenance supervisor (MS) confirmed the kitchen and housekeeping staff were responsible for de-liming the the sinks in the dining room and kitchen area. The MS indicated he did not have any cleaning logs for these areas. Review of facility policy titled, Cleaning and Sanitation of Dining and Food Services undated, indicated the food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. 10/19/18 requested policy in regards to labeling and dating food items, one was not provided.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and	F 880		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 10/19/2018

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F 880	Continued From page 94 controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 95 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include timely surveillance data, including viral infections and illnesses not treated with antibiotics to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 41 residents who currently resided in the facility. Further, the facility failed to ensure the common use blood glucose meter machines were disinfected according to current manufacture's recommendation after resident use on 2 of 2 units, for 11 residents (R41, R42, R27, R144, R26, R24, R23, R30, R11, R33, R19) who received blood glucose testing. In addition, the facility failed to perform proper hand hygiene prior to sterile glove use for 1 of 1 residents (R10) observed while completing tracheostomy suctioning procedure. Findings include: INFECTION CONTROL PROGRAM Review of the facility forms titled Frazee Care Community Infection Control Log from January	F 880	o R27, R26, R11, R33, R19 have had blood glucose monitoring in accordance with proper manufacturers recommendation for disinfection of the blood glucose machine o R41, R42, R144, R24, R23, R30 have not been identified on the survey resident sample list provided by MDH o R10 has had tracheostomy care with proper infection control process pertaining to hand hygiene. o All residents who use glucometer could be affected, none show ill affect o All residents with procedures requiring sterile glove use could be affected, none show ill affect o Surveillance for infection is ongoing for all residents o Education and competency provided to licensed nurses on disinfection of glucometers in accordance with manufacturers recommendation o Education and competency provided to licensed nurses on procedure for sterile gloves	

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F 880	Continued From page 96 2018, to October 2018 revealed the following: The forms included the month and year. They also included columns of date, name of resident, room number, signs and symptoms, X-Ray results, UA (urine analysis) results, medications, precautions, present on admit, acquired in house and date resolved. All areas were completed on forms for the entries listed below. -January 2018, one resident was identified with wheezing, rhonchi, diminished breath sounds and fever, treatment with Augmentin. No further illnesses or viral infections were listed. -February 2018, four residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -March 2018, two residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -April 2018, four residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -May 2018, eight residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed. -June 2018, fourteen residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections	F 880	o Education has been provided to nursing staff on infection control surveillance, monitoring and trending of infections to include viral infections and illness not treated with antibiotic o Audits will occur weekly for 2 residents for 4 weeks then monthly for 2 months to ensure infection control surveillance is accurate and ongoing. o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date. 11/28/2018	

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F 880	Continued From page 97	F 880		

were listed.

-July 2018, ten residents were identified with various symptoms. All were treated with antibiotics. First page identified eight residents in sequence from 7/3/18, to 7/20/18. Second page included two residents identified on 7/10/18, then 7/15/18. No further illnesses or viral infections were listed.

-August 2018, five residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed.

-September 2018, fourteen residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed.

-October 2018, four residents were identified with various symptoms. All were treated with antibiotics. No further illnesses or viral infections were listed.

On 10/19/18, at 11:41 a.m. director of nursing (DON) indicated she completed the infection control surveillance forms. DON confirmed the facility only tracked those residents who received antibiotic treatment and did not complete tracking on weekends. DON indicated she read resident progress notes daily when she was present and checked for any new infections and orders. DON indicated she reviewed the weekend notes for infections on Mondays.

The facility policy titled Infection Prevention and Control (General) revised 11/2016, specified a

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 880	Continued From page 98	F 880		

system was in place that prevents, identifies, reports, investigates, and controls infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing service under a contractual arrangement and following accepted national standards. The policy further identified a system was in place for surveillance designed to identify possible communicable disease or infections before they could be spread to other persons in the facility.

DISINFECTION BLOOD GLUCOSE MACHINE

R26 was observed on 10/17/18, at 6:15 p.m. seated in a recliner with her supper meal positioned to her right on a side table. RN-B entered R26's room carrying a white plastic container, which held an EvenCare G3 blood glucose testing meter, a small bottle of test strips, multiple lancets, and multiple alcohol wipes that were individually wrapped. RN-B applied gloves and picked up the glucose meter out of the white plastic container and placed a test strip. RN-B then cleansed R26's finger using an alcohol wipe, obtained a sample of R26's blood from the finger, and obtained a blood glucose reading from the glucose meter. RN-B then removed the used test strip from the meter and placed the meter back into the white container on top of the test strips bottle, lancets, and alcohol pads. She then left R26's room. At 6:20 p.m. RN-B placed the white container back into a drawer of the medication cart, and walked away from the medication cart. RN-B made no attempts to disinfect the blood glucose monitoring machine.

On 10/17/18, at 7:57 p.m. RN-B stated the Even

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F 880	Continued From page 99 Care G3 glucose meter was a common use glucose meter and was used for any resident on the A wing with orders for blood glucose testing. RN-B stated staff used a Micro-Kill One disinfecting wipe to clean the meter, and this was done once per sift. On 10/19/18, at 8:53 a.m. the DON confirmed the EvenCare G3 glucose meters were common use in the building and could be used for any resident that had an order for blood glucose testing. The DON indicated her expectation for disinfecting the glucose meter would be to disinfect the meter using the Micro-Kill One wipes, between each resident use. She stated, staff should not place the meter back into the carrying container until sanitized, as all the supplies in the container would then be contaminated if the meter was not sanitized prior. On 10/19/18, at 9:00 a.m. the DON provided the EvenCare G3 User's Guide, undated. The guide's Table of Contents, 6. Caring For the Meter, was reviewed. 6. Caring for the Meter instructed the user the meter should be cleaned and disinfected between each patient. The instructions listed several products which had been approved for cleaning and disinfecting the EvenCare G3 meter, which included: Medline Mirco-Kill+ (plus) and Medline Mirco-Kill Bleach. However, the list did not include Micro-Kill One. The guide indicated other EPA registered wipes may be used for disinfecting the EvenCare G3 system, however, these wipes had not been validated and could affect the performance of the meter. On 10/19/18, at 10:08 a.m. licensed practical	F 880		

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F 880	Continued From page 100 nurse (LPN)-C indicated she worked on Wing A, and stated she sanitized the EvenCare G3 meter between each resident utilizing the Micro-Kill One wipe. On 10/19/18, at 10:13 a.m. LPN-B indicated she was working on Wing B and the glucose meter on Wing B was a common use glucose meter. She stated she sanitized the EvenCare G3 meter between each resident utilizing the Micro-Kill One wipe. On 10/19/18, at 10:24 a.m. Medline customer service representative (MCSR)-A stated Micro-Kill One was not the same product as Micro-Kill+ or Micro-Kill Bleach, and stated the difference in each product was the main ingredient of the wipe. MCSR-A stated, Micro-Kill One had not been tested on the EvenCare G3 meter. MCSR-A stated the recommendation would be to follow the EvenCare G3's User Guide's instructions for disinfecting. On 10/19/18, at 10:36 a.m. during a follow up interview with the DON, she stated she would expect the facility would follow the EvenCare G3's manufacturer's recommendations for disinfecting the meter. DON confirmed 11 residents (R41, R42, R27, R144, R26, R24, R23, R30, R11, R33, R19) used this blood glucose machine. Review of the facility policy titled, Glucometer Infection Control Guidance, dated 3/14, indicated glucometers which were shared between more than one resident would be disinfected between each resident use. The policy further indicated to use an Environmental Protection Agency	F 880		

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F 880	Continued From page 101	F 880		

(EPA)-Registered disinfectant effective against hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV), and to use the products as directed by the manufacturer.

HAND HYGIENE
R10's quarterly Minimum Data Set (MDS) dated 8/2/18, identified R10 was cognitively intact, required total assistance with activities of daily living (ADL) and was able to use his electric wheelchair independently with supervision. R10's MDS also identified diagnoses which included cerebral palsy (permanent movement disorder that usually appeared in early childhood) anxiety and respiratory failure. R10's MDS further identified he used oxygen, required suctioning, tracheostomy care and ventilation.

R10's care plan last reviewed 8/7/18, identified ventilator dependent and tracheostomy due to chronic respiratory failure with hypoxia (condition which the body or region of the body is deprived of oxygen). R10's care plan further indicated to suction tracheostomy PRN (as needed) and at least 1 time per shift.

On 10/17/18, at 2:36 p.m. R10 was lying in bed, with the head of his bed slightly elevated. Registered nurse (RN)-A was in the room, getting supplies ready for suctioning. RN-A began looking for the suction kit, when R10 informed her the supplies were in the top drawer of the bed side table. RN-A removed the suction kit from the bed side table top drawer and placed the suction kit on the bedside table. RN-A then removed the package cover and opened and unfolded the sterile gloves. R10's ventilator

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F 880	Continued From page 102	F 880		

alarm began to sound. R10 indicated the alarm would stop sounding once he was suctioned. RN-A walked to the door, opened the door with the doorknob, reached up and turned off the alarm, which was located outside his room near his door, then she re-entered R10's room and used the door knob to close the door. RN-A walked back to the bedside table, then applied the sterile gloves without performing hand hygiene. RN-A then began to suction R10 through his tracheostomy ventilator tubing while wearing the sterile gloves.

On 10/17/18, at 6:59 p.m. RN-A indicated she had sanitized her hands when she first entered the room, but forgot to perform hand hygiene after touching the bedside table drawer handle, opening the kit, touching R10's door knob twice and turning off the ventilator alarm outside his door. RN-A indicated she should have preformed hand hygiene prior to putting on the sterile gloves and indicated this was important.

On 10/18/18, at 11:56 a.m. DON indicated she would absolutely expect proper hand hygiene be preformed prior to applying sterile gloves for suctioning. DON indicated if hand hygiene was not preformed prior to applying sterile gloves, this could pass germs along and cause a potential infection.

On 10/19/18, at 9:51 a.m. clinical manager (CM)-A indicated she preformed ventilator training, and the licensed nurses did suction training during orientation. CM-A indicated hand washing for infection control was important.

The facility policy titled Hand Washing dated

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F 880	Continued From page 103 4/1/18, identified staff were to wash their hands after each direct resident contact for which hand-washing was indicated by accepted professional practice. Hand-washing was also conducted per recommendations from the CDC (Centers for Disease Control and Prevention) guidelines. The policy lacked direction for hand washing prior to sterile glove application.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program with established protocols to help reduce unnecessary antibiotic use and reduce potential drug resistance. The program also lacked documentation of appropriate antibiotic use and documentation of education provided to staff and residents on antibiotic stewardship. This deficient practice had the potential to affect all 41 residents who currently resided in the facility. Findings include: The facility policy titled Infection Prevention and Control: Antibiotic Stewardship Program dated	F 881	o An antibiotic Stewardship policy has been developed with protocols to help reduce unnecessary antibiotic use and reduce potential drug resistance o All current antibiotics reviewed for appropriate use and follow up if indicated o Education provided to nursing administration and nurse managers on antibiotic stewardship policy and procedures o Education provided to clinicians and residents on antibiotic resistance and opportunities for improvement o Audit of antibiotic stewardship reviews will be conducted two times weekly for four weeks and then weekly for	11/28/18

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F 881	Continued From page 104 10/14/17, identified the Health Dimensions Group (HDG) communities would implement an Antibiotic Stewardship Program (ASP) to promote appropriate antibiotic use while optimizing the treatment of infections and reduce the possible adverse events associated with antibiotic use. The policy further indicated the ASP would include education for clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improvement. The policy indicated the facility ASP team would include a report for the number of residents on antibiotics that did not meet criteria for active infection. Actions listed included improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection and optimize us of diagnostic testing. The policy further identified an action to establish infection criteria to educate and guide antibiotic prescribing. The policy identified tracking to include DON or IP (infection preventionist) to collect data which included type of antibiotic ordered, type of order received, if attending physician or on-call doctor, when appropriate tests such as cultures were obtained before antibiotic ordered and if antibiotic was changed during the course of the treatment. The policy did not include the antibiotic stewardship program or protocols to be reviewed prior to the initiation of the antibiotic. Review of the facility forms titled Frazee Care Community Infection Control Log from January 2018, to October 2018 indicated the facility identified the individual resident, the date an antibiotic was initiated and the type of antibiotic used. The log did not indicate which antibiotic	F 881	one month and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date. 11/28/2018	

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F 881	Continued From page 105 stewardship protocol had been reviewed prior to the initiation of the medication. On 10/18/18, at 11:41 a.m. director of nursing (DON) reviewed facility antibiotic stewardship program with surveyor. DON confirmed the facility did not not have written protocols regarding the use of the antibiotics. The DON confirmed since the facility had not developed protocols, no education had been provided to the staff or families regarding antibiotic stewardship.	F 881		