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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 23SE
Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245298**
2. STATE VENDOR OR MEDICAID NO. (L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT TWIN RIVERS LLC**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (L6) **55303**

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) **03/01/2017**
6. DATE OF SURVEY **01/23/2018** (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) **12/31**

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 02/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/29/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1985** (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. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **02/02/2018** (L33)

DETERMINATION APPROVAL

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

The facility's request for a continuing waiver of the following health deficiency has been forwarded to the CMS Region V Office for its determination:

F-912 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LAST 80 SQ FT/RESIDENT.

Approval of the waiver request has been recommended.

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

CMS Certification Number (CCN): 245298 February 23, 2018

Ms. Becky Willett, Administrator
The Estates at Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

Dear Ms. Willett:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective January 10, 2018 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds. Your request for waiver of F-912 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

Electronically delivered February 23, 2018

Ms. Becky Willett, Administrator
The Estates at Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

RE: Project Number S5298029

Dear Ms. Willett:

On December 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2017. 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 January 23, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2017, effective January 10, 2018 and therefore remedies outlined in our letter to you dated December 18, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F-912 at the time of the December 1, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2018

Ms. Becky Willett, Administrator
The Estates at Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

Re: Reinspection Results - Project Number S5298029

Dear Ms. Willett:

On January 23, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2017, with orders received by you on December 18, 2017. At this time these orders were found to be corrected.

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,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

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Facility ID: 00866

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(L5) **ANOKA, MN** (L6) **55303**

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) **03/01/2017**
6. DATE OF SURVEY **12/01/2017** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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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
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE: Jennifer Bahr, HFE-NE II — Date: 01/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Anne Peterson, Enforcement Specialist — Date: 2/02/2018 (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)
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25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
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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. **01111** (L31)

30. REMARKS
Annual Health Waiver sent to CMS 02/15/2018 Co.

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

The facility's request for a continuing waiver of the following health deficiency has been forwarded to the CMS Region V Office for its determination:

F-912 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT.

Approval of the waiver request has been recommended.

Electronically delivered
December 18, 2017

Ms. Becky Willett, Administrator
The Estates at Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

RE: Project Number S5298029

Dear Ms. Willett:

On December 1, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 1, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

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

Sincerely,

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING ______ B. WING ______	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	**305 FREMONT STREET ANOKA, MN 55303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On , 11/28/17 through 12/1/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). The Estates at Twin Rivers was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		1/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/27/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING ______ B. WING ______	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	**305 FREMONT STREET ANOKA, MN 55303**

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F 645	Continued From page 1 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual	F 645		

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F 645	Continued From page 2 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Level II preadmission screening resident review (PASRR) was completed for 1 of 1 residents (R17) reviewed for preadmission screening. Findings include: R17's diagnoses, as identified on the facility face sheet with a print date of 12/1/17, included recurrent, major depressive disorder and bipolar disorder. The face sheet indicated R17's admission date to the facility was 9/29/17. During observation on 11/29/17, at 11:50 a.m. R17 was groomed and dressed for the day, seated on her bed in her room, and conversing with a visitor. A review of R17's medical record included a document from the Senior LinkAge Line. The document, dated September 29, 2017 was the initial pre-admission screening results requested by R17's hospice provider, prior to R17's current	F 645	PASRR was obtained for Resident R17. Admission team and facility management team members that assist with admissions will be educated on PASRR and the importance of completed screen to be provided to the facility prior to admission. SW or assigned facility representative to review PASRR with admission paperwork and facilitate any necessary follow up. Screens indicating a Level 2 will have a scheduled follow you from the count and facility representative will follow up with the county if Level 2 documentation is not received. Facility Audit completed of the PASRR to ensure that all residents have received the appropriate follow up. Admissions will be audited upon admission to ensure PASRR compliance for 1 month and then as needed.	

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F 645	Continued From page 3	F 645		

placement in the nursing home. The document indicated in the section OBRA (Omnibus Budget Reconciliation Act) Level 1 MI (mental illness): It appears "this person [R17] meets the criteria for MI and needs to be referred to the lead agency for further evaluation." A further review of R17's medical record indicated there was no level 2 PASRR screen currently completed.

When interviewed on 11/20/17 at 12:40 p.m., the director of social services (DSS) stated R17's 'PAS' (pre admission screen) identified a level 2 screening was indicated. The DSS stated she made a call in early October, shortly after R17's admission, to Hennepin County regarding follow up to get the level 2 screen for R17 and thought one may have been completed but was unable to find it. The DSS stated she would contact Hennepin County today, and expected a FAX of the level II screening.

R17's care plan, with a start date of 10/10/17, identified mood and behavior and activities as problem/strength areas; however, the care plan did not identify any diagnosis-specific interventions or other therapeutic-programming needs for R17.

R17's physician's orders, dated 9/29/17, did not identify any order for special therapy, programming, or other mental health services.

A review of R17's progress notes from 9/1/17 to 11/30/17, included documentation regarding R17's PASRR on 10/4/17. Subsequent progress notes regarding R17's case with Hennepin County, and Anoka County were documented as having took place during the survey (11/18 to 12/1/17).

Director of Social Services or designee will be the responsible party.

QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.

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F 645	Continued From page 4 During a subsequent interview on 11/30/17 at 3:00 p.m., the DSS stated when she subsequently contacted Hennepin County, whom she thought would complete the level II evaluation, she learned that a screen had not been completed, and a case worker essentially closed the file. The DSS also stated Anoka County had been involved in R17's case and there were referrals made, but none having to do with a PASRR Level II for R17. The DSS stated there were mix-ups with contact information, and acknowledged "there was no current" level II screen completed for R17. A facility policy, Pre-Admission Screening (PAS), revised 1/2017, indicated it's purpose was "To ensure that residents admitted to the health care center meet specified criteria for appropriateness of placement. The policy direct under #1: The social worker will check for preadmission screening and OBRA Level II requirements.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		1/10/18

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F 656	Continued From page 5 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the faciltiy failed to ensure comprehensive care plans were developed for range of motion (ROM), splints and activities for 1 of 7 residents (R15) who were dependent upon staff for activities of daily living and rehabilitation. Findings include: ROM AND SPLINTS	F 656	Resident R15 is provided a functional range of motion program as recommended by therapy, to include a splint applied at bedtime and removed in the morning. R15's care plan has been updated to reflect range of motion program and splint use, and activity goals, participation, and interventions implemented to meet identified needs.	

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F 656	Continued From page 6 R15's annual MDS, 10/2/17, identified R15 had no upper or lower extremity impairments, no rejection of cares and was not involved in a nursing rehabilitation program. Review of R15's Occupational Therapy (OT) note, 9/26/16 identified R15 had right hemiparesis (paralysis right side of body) with trace movement of his right fingers, no active range of motion in elbow or shoulder, and PROM within functional limited with verbalization of pain when should flexion past 140 degrees. The Therapy Communication form dated, 10/31/16, identified for nursing to apply right hand splint to R15 at hour of sleep and remove with morning cares and clean his hand. Review of the facility Therapy Communication form, dated, 12/1/2016, identified functional maintenance program (FMP) provide ROM to right upper extremity twice a day, five repetitions to shoulder, elbow and wrist. The occupational therapy (OT) discharge summary, 12/2/16, identified nursing to continue right upper extremity ROM, and right hand splinting schedule on at night and off during the day. Review of R15's occupational therapy note, 9/25/17 identified bilateral upper extremity passive range of motion (PROM) within functional limits. Limited range of motion related to hemiparesis/brain injury. Nursing reports (R15) on functional maintenance program (FMP) for PROM in place from previous therapy in nursing care plan.	F 656	All residents will continue to be offered any maintenance program as recommended by therapy. Audit of therapy record and nursing has been completed to ensure that they are included in the plan of care. Nursing staff will follow recommendations and re-approach and/or document upon refusals. Process has been implemented to improve therapy to nursing communication. Nursing will continue to provide proper ROM. An audit of all dependent residents care plans was completed by therapeutic program director on December 20, 2017. These activity care plans include goals and interventions. Education has been completed with therapy and clinical staff regarding the newly revised communication process to include nurse manager initially receiving all therapy communications and ensuring plan of care is developed and followed. Education will be provided to the Therapeutic Program Director on ensuring that all residents are assessed for activity preferences, goals, and participation logs are completed. Range of motion audits will be completed by Director of Nursing or designee weekly x4 and as needed. During this audit, nursing will collaborate with therapy and ensure recommendations are current on the care plan, point of care and nursing assistant care guides. Activity plans will be audited weekly x4 for activity goals and as needed.	

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F 656	Continued From page 7 The physical therapy note 10/3/17 identified a FMP was in place and to continue the program, (R15) has not changed or declined. R15's care plan, print date 12/1/17, identified a problem with physical functioning related to mobility impairment, but did not address the use of a right hand splint or any restorative nursing program as part of the care plan. Review of the facility treatment administration record (TAR) from September 2017 through November 2017, did not identify any range of motion, or any hand splint identified as part of the TAR. Review of the facility Team #4, nursing assistant sheets, a form used by nursing assistants identified under R15's ADL's were "Right hand splint on when in bed, off in AM [morning]." There was no mention of any nursing rehabilitative program on this sheet. During interview on 12/01/17 12:13 p.m. Director Physical Therapy (DPT) stated R15 was on a functional maintenance program with PROM on 3/16/17 and the last therapy note on 10/3/17 identified he was still on that program and a splint to right hand. There was no mention that R15 FMP or splinting program had been stopped and he should still be receiving this as identified in the therapy notes. In an interview on 12/01/17 12:35 p.m. director of nursing (DON) stated she was aware (R15) had a right hand splint, but did not know (R15) had a FMP PROM program. The DON reported R15's care plan did not identify the right hand splint or the FMP PROM program which should be	F 656	Administrator or designee will be responsible. QAPI committee rill review results and provide redirection or change when necessary and dictate continuation or completion of this mentoring process based on compliance.	

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Continued From page 8
included as part of the care plan.

ACTIVITIES
R15's annual Minimum Data Set (MDS) dated, 10/2/17 identified R15 had severe cognition, needed extensive to total assistance for all activities of daily living, and activity preferences were identified by the resident. The MDS identified R15's preferences of books, newspaper, music, animals, news, being with group of people, important favorite activities, going outside and religious services were all not very important.

Review of the faciltiy MHM Activity Participation Review, dated 10/2/17 identified under the attendance and participation summary. The resident has joined group activities infrequently such as meals in the dining room, snack cart and current events. Resident enjoys impendent activities such as watching TV and sports. Resident does attend dialysis three times a week which limits participation. Resident's favorite activities as identified as he prefers visits form family and independent activities. Resident enjoys watching sports. Resident if proud of being a military veteran. and the activity plan review identified the plans remain appropriate/current as per care plan, goal were met and interventions were effective in reaching goal.

Review of R15 care plan print date, 12/1/17, did not have any information about activity goals, participation or interventions implemented to meet R15's activity needs.

During interview on 12/01/17 11:41 a.m. Therapeutic recreation director (TRD) stated they

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F 656	Continued From page 9 do a quarterly review of his activity participation before his care conference, and then an annual evaluation under section F of the MDS. On a monthly basis we track his participation. She was unsure of what R15's activity goals were or how this was measured on the care plan. Although R15 was dependent upon staff, and was unable to physically participate in activities without staff assistance, the facility had not completed a comprehensive care plan to meet his activity needs.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		1/10/18

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(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 2 of 3 residents (R1, R25) reviewed for accidents, 1 of 3 (R15) residents reviewed for pressure ulcers, 1 of 3 residents (R34) reviewed for incontinence, and 1 of 5 residents (R26) reviewed for medication.

Findings include:

ACCIDENTS
R25 had the diagnoses of alcohol-induced persisting dementia and cirrhosis of the liver, nicotine dependence, essential hypertension and anemia identified on the facility undated face sheet. The annual minimum data set (MDS), dated 10/20/17, indicated R25 was cognitively intact and require limited assistance with activities of daily living (ADLs). The Care Area Assessment (CAA) for ADLs indicated R25 needed assistance with ADLs, this resident did not liked being helped, and the assistant level varied from day to day.

R25 was observed returning back inside after smoking on 11/29/17 at 6:27 p.m.. R25 was noticed not to have any clothing or shin burns. R25 stated he is not supervised nor adaptive equipment such as a smoking apron.

During a medication pass observation on 11/30/17 at 8:10 a.m., R25 asked licensed

Resident R25 has a current smoking assessment completed and care plan updated, R1 care plan was updated to reflect current bed/mattress being used, R34 care plan was made current to reflect current bowel and bladder needs, R26 had antidepressant and anticoagulant use and monitoring removed from care plan, R15 care plan updated to reflect current turning and repositioning schedule.

Licensed nurses will update care plans as needed with changes of condition and with quarterly and annual assessment. A complete care plan audit remains in process for all current residents residing at the Estates at Twin Rivers. All smoking, pressure ulcer, turning and repositioning, bowel and bladder, and orders were reviewed for all pertinent residents. Care plans were reviewed and updated on December 26, 2017.

Nurses will be educated on an ongoing basis on how and when to update care plans as appropriate.

Random care plan revision audits will be completed weekly x 4 as indicated. Re-education will then be provided with documentation if warranted.

Director of Nursing or designee will be

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practical nurse (LPN)-A for two cigarettes, which were stored in the medication cart. While observing R25 smoke, resident did not display any unsafe smoking behaviors. LPN-A stated the facility holds R25's cigarettes in the medication cart and has 3 times a day he smokes where he is given 2 cigarettes each time. LPN-A stated that (R25) was independent with smoking and doesn't wear a smoking apron.

In review of R25's smoking assessments, entitled: MHM Smoking Evaluation, last assessed 10/24/17, the facility indicated: "Resident is independent with smoking. Resident has had a issues once or twice in the past 3-4 months of accidentally dropping his cigarette, however no concerns at present." In further review of previous assessments, dated 8/24/17, R25 needed supervisor, and the assessment dated 3/23/17, indicted R25 needed a smoking apron. There was no mention for the use of a smoking apron on the 10/24/17 assessment.

Review of R25's care plan (initiation date of 11/03/15), indicted: "At risk for smoking related injury related to: Smokes with supervision. The Goal indicated: "I will have no smoking related injuries." The interventions included: that the facility would "observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources..." and that the facility would "provide smoking apron while smoking."

During an interview on 11/30/17 at 12:10 p.m., the director or nursing (DON) stated the facility is still "supervising R25 with his smoking, even if they are not outside, while they are holding on to his cigarettes." The DON stated the smoking apron

Provider's plan of correction (F 657):

responsible.

QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.

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F 657	Continued From page 12 was no longer worn due to resident refusals. R1's admission Minimum Data Set dated 8/17/17, indicated R1 had no speech and was rarely understood and had moderately severe depression. The MDS indicated R1 needed total assistance to transfer and extensive assistance with locomotion on the unit. Diagnoses included aphasia (loss of ability to understand or express speech, caused by brain damage) stroke and schizoaffective disorder. The MDS indicated R1 had two or more falls without injury since admission. R1's care plan dated 11/10/17, indicated R1 was at risk for falls and indicated a concave mattress was in place. During observation on 11/29/17, at 6:00 p.m. R1 was lying in a bariatric sized bed without a concave mattress. During interview on 11/29/17, at 7:43 p.m. NA-J stated R1 used to have a concave mattress but his mattress was replaced with a larger bed. NA-J did not know when the mattress was replaced. During interview on 12/1/17, at 10:27 a.m. DON stated R1's concave mattress was replaced with a bariatric bed as R1 moves a lot in bed, and thought that would help prevent falls. DON stated care plan should have been revised to reflect current interventions. Documentation on when the mattress was changed was requested and was not received. INCONTINENCE	F 657		

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R34's admission MDS dated 10/6/17, identified R34 had an indwelling catheter and was frequently incontinent of bowel. R34's care plan dated 9/29/17, indicated R34 had an alteration in eliminations and had a Foley catheter and rectal tube in place related to unstageable pressure ulcers.

R34's Doctor Order Sheet dated 10/6/17, directed staff to discontinue the rectal tube.

R34's Doctor Order Sheet dated 10/13/17, directed staff to discontinue the Foley catheter.

During observation on 11/28/17, at 10:36 a.m. R34 was having wound care done to his buttocks and did not have a Foley catheter or rectal tube in place.

During interview on 12/1/17, at 9:54 a.m. DON stated R34's care plan should have been revised when R34's rectal tube and Foley catheter were removed.

PRESSURE ULCERS
R15's annual Minimum Data Set (MDS) dated, 10/2/17 identified R15 had severe cognition, needed extensive to total assistance for all activities of daily living, was at risk for pressure ulcer (PU) development, and a current stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed). R15 received treatment of pressure reductions devices in chair, bed and was on a hydration program and PU treatment program.

R15's pressure ulcer care area assessment, 10/13/17 indicated R15 has a stage 2 PU to right

F 657

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F 657	Continued From page 14 gluteal, seen by wound nurse practitioner, treatment per order, air mattress to bed. Resident was incontinent of bowel and bladder, needs assistance with turning and repositioning. Braden scale (scoring system to determine risk level for PU) was 14 (moderate risk) risk for further breakdown. Although the assessment identified for R15 was turned and repositioned, but the frequency was not identified. R15's care plan print date 12/1/17 identified R15 was at risk for PU development and had a history of stage 3 and 2 pressure ulcers with a current stage 2 PU on his coccyx. Staff were directed to conduct a weekly skin assessments, provide pressure reducing cushion in chair, and bed, apply barrier cream after incontinence, toilet plan and turn and reposition schedule per assessment. Although the assessment identified there was a turning and repositioning schedule, this was not added to the care plan. During interview on 11/30/17 at 2:00 p.m. LPN-E stated (R15's) care plan was not specific for a turning and repositioning schedule and it should be. MEDICATIONS R26 had the diagnoses of chronic congestive heat failure (CHF), major depression, chronic pain, chronic kidney diease, anemia, and essential hypertension, undated facility face sheet. The quarterly Minimum Data Set (MDS), dated 11/03/17, indicated R26 was cognitively intact and require staff set up and limited assistance with toileting.	F 657		

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F 657	Continued From page 15	F 657		

R26 was admitted to the hospital during the first day of survey (11/28/18) and returned to the facility the last day of survey (12/01/17).

In review of R26's care plan (initiated dated of 8/03/17), it was noted that the facility had identified the two following concerns for monitoring medication:

1. "The resident in on Anticoagulant therapy Coumadin (a blood thinner) r/t [related to: diease process of DVT [deep vein thrombosis], pulmonary embolism [blood clots to the lungs]." The intervention section directed staff to monitor sign and symptoms of bleeding, and medications to avoid.

2. "Potential for psychotropic drug ADR's [adverse drug reactions] r/t [related to] daily use of psychotropic medication. Receives Cymbalta (an antidepressant) for the diagnosis of depression." The staff were directed to being tapering the medication for discontinuation, and update the MD (physician/PA (physician assistant) regarding efficiency of the medication.

In review of R26's physician's orders, dated 10/26/17, there was no indication that R26 was receiving either Coumadin or Cymbalta. In further review, it was documented that the facility received an order on 8/15/17 to decrease the Cymbalta to 60 milligrams (mg) everyday, and that it was OK to discontinue this medication after 2 week if symptoms do not return. The facility received an order on 10/11/17 to discontinue the Coumadin medication.

During interview on 12/01/17 at 8:30 a.m., the

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F 657	Continued From page 16 director of nursing (DON) stated that R26's care plan was not revised after the discontinuation of both the Coumadin and Cymbalta medications. A policy on care plan revisions was requested and was not provided by the facility.	F 657		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for activities, oral care and shaving facial hair for 3 of 5 residents (R39, R15 and R1) reviewed who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: ACTIVITIES R1's admission Minimum Data Set dated 8/17/17, indicated R1 had no speech and was rarely understood and had moderately severe depression. R1 care plan dated 11/10/17, indicated R1 had altered socialization due to the inability to communicate. Goals for R1 included R1 would continue daily independent activities in his room and participate in short one on one weekly visits.	F 659	R1 activity plan of care/care guide has been updated to provide further communication to the clinical team and other disciplines. Staff to assist R1 up per shift and stay with resident. IPad and TV available for stimulation; nursing staff to offer. R39 ADL care plan has ben updated to reflect current oral care needs and refusals. Risk and benefits regarding oral care refusal has been completed and staff will continue to offer assistance. R15 personal hygiene care plan has been update to reflect current needs and preference including shaving and staff will continue to assist as indicated. All residents will continue to be provided care as outlined by their individual/comprehensive care plan. All resident's were audited and care planned	1/10/18

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F 659

Continued From page 17

Interventions included providing R1 with with stimulating music, television and other activities.

During observations on 11/28/17, at 9:00 a.m. to 2:28 p.m. R1 was lying in bed with the lights on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) from staff.

During interview on 11/28/17, at 2:30 p.m. family member (FM)-A stated R1 when the family visited, on almost a daily basis) R1 was always lying in bed without any music or television.

During observations on 11/29/17, at 1:00 p.m. to 6:20 p.m. R1 was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) from staff.

During interview on 11/29/17, at 7:43 p.m. nursing assistant (NA)-J stated R1 spent most of his time lying in bed and didn't have music or a television on for any stimulation.

During observations on 11/30/17, at 6:54 a.m. through 12:37 p.m. was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) from staff.

During interview on 12/1/17, at 10:27 a.m. director of nursing (DON) stated R1's current care plan should be followed.

ORAL CARE
R39's diagnoses, as identified on the annual Minimum Data Set (MDS) assessment dated

F 659

to their individual preference.

Staff including clinical department will be re-educated on reviewing, following and providing cares based upon the resident's plan of care including personal hygiene and activity needs.

Audits will be completed weekly x 4 weeks, then as needed regarding; specific resident care planned cares such as oral cares, shaving, and giving opportunities for stimulating activity.

Director of Nursing or designee will be responsible.

QAPI committee will review results and provide redirection or change when necessary and dictate continuation of completion of this monitoring process based on compliance date.

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F 659	Continued From page 18 9/27/17, included cognitive, social or emotional deficit following cerebral vascular disease (stroke) and left hemiplegia, and also indicated R39 required extensive assistance of staff to complete ADLs. The MDS also indicated R39 had intact cognition. R39's care plan, revised 7/12/17, identified R39 had a physical functioning deficit, but was able to brush teeth after set up. During observation on 11/30/17 beginning at 6:51 a.m., licensed practical nurse entered R39's room to take his blood sugar. After getting the blood sugar, LPN briefly exited the room and provided R39 with some milk and jelly to eat in response to the lower blood sugar. At 8:22 a.m., licensed practical nurse (LPN)-A entered R39's room to re-check a blood sugar, and left the room when nursing assistant (NA)-B greeted R39 to begin morning cares. NA-B gathered care supplies, towels and clothing and began R39's morning routine. NA-B washed and dressed R39, then placed a lift sling under R39. Using a mechanical lift, and with assistance of NA-E, NA-B transferred R39 from the bed into the wheelchair. NA-B groomed R39's face, combed his hair, and asked R39 if there was anything else he needed, to which R39 shook his head. During this morning routine, NA-B did not offer or provide any oral cares for R39. NA-B told R39 she would take him to breakfast, then exited the room carrying the bagged, soiled items from the room. Upon return to the room at 8:44 a.m., NA-B transported R39 into the dining room for breakfast, again without offer of oral cares. Following breakfast at 9:43 a.m., NA-B wheeled R39 back to his room, where R39 expressed wanting to remain in the wheel chair and watch TV. NA-B adjusted the TV and headphones to	F 659		

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F 659	Continued From page 19	F 659		

R39's likings, placed the call light on the wheel chair and exited R39's room. Again there was no provision nor offer to provide oral cares to R39 following breakfast. R39 remained in his chair until after he was assisted to eat the noon meal in his room at 12:08 p.m.

When interviewed on 11/30/17 at 12:30 p.m., NA-b stated she had lots of residents to assist this morning and missed to offer R39 oral cares. " I just forgot to offer tooth brushing." She stated that (R39) was dependent upon staff to complete his oral cares.

During interview on 11/30/17 at 1:02 p.m., LPN-A stated the care plan should be followed and R39 should be offered and assisted as need to do his teeth. LPN-A stated staff need to try, and try more than once if needed, and added R39's teeth brushing "should have been done."

When interviewed on 12/1/17 at 8:49 a.m., the director of nursing (DON) stated oral cares should be at least offered in the morning and evening to all residents. The DON stated she expected oral cares needed to be offered to residents, not forced, but if refused, to re-approach or have another caregiver try. The DON stated staff were to offer oral cares "at least twice daily."

SHAVING
R15's annual Minimum Data Set (MDS) dated, 10/2/17 identified R15 had severe cognition, needed extensive to total assistance for all activities of daily living, and had no rejection of cares.

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F 659	Continued From page 20	F 659		

R15's care plan print date 12/1/17 identified R15 was physical functioning deficit related to self care impairment and ability with ADL's can vary. Staff were directed to provide personal hygiene assistance of one.

R15 was observed on 11/28/17 10:08 a.m. in his bed watching television, he was unable to communicate and had visible facial hair. On 11/29/17 5:56 p.m. R15 was at nursing station unshaven with visible facial hair. On 11/30/17 at 6:49 a.m. R15 was in his wheelchair and dressed for the day. He was unshaven and had visible facial hair approximately 1/8 inch long. At 12:30 p.m. R15 was in bed watching television with visible facial hair and had not been shaven for the past few days. On 12/01/17 at 8:58 a.m. R15 continued to be unshaven with visible facial hair and left for dialysis at approximately 10:00 a.m. unshaven.

During interview on 12/01/17 11:08 a.m. licensed practical nurse (LPN)-E stated they were responsible for (R15's) shaving and the nursing assistants (NA's) are suppose to do this, whenever he has "lots of beard." At 11:10 a.m. NA-H who was R15's NA for the day stated she shaves (R15) when he is "scruffy." I was going to shave him today but dialysis come and got him. They do not shave him every day, only when it is needed because he pulls away when we try to shave him. During this time NA-G stated she took care of him on Thursday (11/30/17) and she did not shave him because he doesn't like his face touched.

Review of the facility Point Of Care form identified one person physical assistance with personal hygiene that included shaving. Review of the

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F 659	Continued From page 21 documentation from 11/18/17 to 12/1/17 had check marks in place for both days and evening shifts which identified personal hygiene was completed for R15. In an interview on 12/01/17 12:35 p.m. director of nursing (DON) stated staff are to follow the point click care documentation when providing cares to residents.	F 659		
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 ensure oral cares and shaving were offered or provided for 2 of 5 residents (R39, R15) in the sample who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R39's diagnoses, as identified on the annual Minimum Data Set (MDS) assessment dated 9/27/17, included cerebral vascular disease (stroke) with left hemiplegia, and identified R39 required extensive assistance of staff to complete ADLs. The MDS also indicated R39 had intact cognition. A care area assessment (CAA) for ADLs, dated 9/27/16, indicated R39 required assistance with dressing, grooming and bathing. The care plan, revised 7/12/17, identified R39 had a physical functioning deficit, but was able to	F 677	R39 Activity care plan has been updated reflect current oral care needs and refusals. Risk and benefits regarding oral care refusals has been completed and staff will continue to offer assistance. Since survey exit, R39 has been offered assistance with oral care each day per his identified preferences by the clinical staff. R15 personal hygiene care plan has been updated to reflect current needs and preferences including shaving and staff will continue to assist as indicated. Since survey exit, R15 has been assisted with shaving by clinical staff. All residents, including new admits, will continue to be provided care and specifically offered assistance with oral care and shaving, as outlined in their individual/comprehensive care plan and	1/10/18

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F 677

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brush teeth after set up.

On 11/30/17, at 6:51 a.m., a licensed practical nurse (LPN) checked R39's blood sugar in his room. The LPN then provided R39 with some milk and jelly to eat in response to the blood sugar. At 8:22 a.m., LPN-A entered R39's room to re-check the blood sugar, and left the room when nursing assistant (NA)-B greeted R39 to begin morning cares. NA-B gathered care supplies, towels and clothing and began R39's morning routine. NA-B washed and dressed R39, then placed a lift sling under R39. Using a mechanical lift and with assistance of NA-E, NA-B transferred R39 from the bed into the wheelchair. Once seated and adjusted, NA-B groomed R39's face, combed his hair, and asked R39 if there was anything else he needed, to which R39 shook his head. During this morning routine, NA-B did not offer or provide any oral cares for R39. NA-B told R39 she would take him to breakfast, then exited the room carrying the bagged, soiled items from the room. Upon return to the room at 8:44 a.m., NA-B transported R39 into the dining room for breakfast, again without offer of oral cares.

Following breakfast at 9:43 a.m., NA-B wheeled R39 back to his room, where R39 expressed wanting to remain in the wheel chair and watch TV. NA-B adjusted the TV and headphones to R39's preference, placed the call light on the wheel chair and exited R39's room. There was no provision or offer of oral cares for R39. R39 remained in his chair until after he was assisted to eat the noon meal in his room at 12:08 p.m.

On 11/30/17, at 12:30 p.m., NA-B stated she had lots of residents to assist this morning and did not offer R39 oral cares stating, "I just forgot to offer

F 677

assessment. All residents were audited and care planned to their individual preference. Since survey exit, all residents have been offered assistance with personal hygiene daily including shaving and oral care per preferences.

Staff including clinical department will be re-educated on reviewing, following and providing care based on the resident's plan of care including personal hygiene, oral care and shaving, daily and/or per the residents plan of care.

Visual audits will be completed weekly x 4 weeks, then as needed to ensure specific resident care planned cares such as: oral care, shaving is being offered daily and/or per the residents preferences.

Director of Nursing or designee will be responsible.

QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.

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Continued From page 23
tooth brushing." NA-B also stated R39 was dependent upon staff to complete his cares.

During interview on 11/30/17, at 1:02 p.m., LPN-A stated the care plan should be followed and R39 should be offered and assisted as need to do his teeth. LPN-A stated staff need to try, and try more than once if needed. LPN-A added R39's teeth brushing "should have been done."

When interviewed on 12/1/17 at 8:49 a.m., the director of nursing (DON) stated at a minimum, oral cares should be offered in the morning and evening. The DON stated she expected oral cares needed to be offered to residents. If refused, staff should reapproach or have another caregiver attempt cares.

A facility document, Oral Hygiene, dated 2/15, identified the purpose of the [Oral Care] procedure was to clean and freshen resident's mouth, remove food particles form between teeth, to maintain the teeth and gums in a healthy condition, to prevent infections of the mouth and to keep the resident's lips and oral tissues moist. The Policy directed staff to offer oral hygiene as indicated on the resident's plan of care.

SHAVING
R15's annual Minimum Data Set (MDS) dated, 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living, and had no rejection of cares.

R15's care plan print date 12/1/17, identified R15 had a physical functioning deficit related to self care impairment and ability with ADL's can vary. Staff was directed to provide personal hygiene

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F 677	Continued From page 24	F 677		

assistance of one.

R15 was observed on 11/28/17, at 10:08 a.m. in his bed watching television, he was unable to communicate and had visible facial hair. On 11/29/17, at 5:56 p.m. R15 was at nursing station unshaven with visible facial hair. On 11/30/17, at 6:49 a.m. R15 was in his wheelchair and dressed for the day. He was unshaven and had visible facial hair approximately 1/8 inch long. At 12:30 p.m. R15 was in bed watching television with visible facial hair and had not been shaved for the past few days. On 12/1/17, at 8:58 a.m. R15 remained unshaven with visible facial hair and left for dialysis at approximately 10:00 a.m. unshaven.

During interview on 12/1/17, at 11:08 a.m. licensed practical nurse (LPN)-E stated they were responsible for (R15's) shaving and the nursing assistants (NA's) are suppose to do this, whenever he has "lots of beard." At 11:10 a.m. NA-H who was R15's NA for the day, stated she shaves [R15] when he is "scruffy." I was going to shave him today but dialysis come and got him. They do not shave him every day, only when it is needed because he pulls away when we try to shave him." During this time NA-G stated she took care of him on Thursday (11/30/17) and she did not shave him because he doesn't like his face touched.

Review of the facility Point Of Care form identified one person physical assistance with personal hygiene which included shaving. Review of the documentation from 11/18/17, to 12/1/17, identified check marks were in place for both days and evening shifts which identified personal hygiene was completed for R15.

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F 677	Continued From page 25 On 12/1/17, at 12:35 p.m. director of nursing (DON) stated staff was to follow the point click care documentation when providing cares to residents.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 2 of 3 residents (R1, R15) who were dependent on staff for activities. Findings include: R1's admission Minimum Data Set dated 8/17/17, indicated R1 had no speech, was rarely understood and had moderately severe depression. The staff interview of family about activities indicated there were no activities important to R1. The MDS indicated R1 needed total assistance to transfer and extensive assistance with locomotion on the unit. Diagnoses included aphasia (loss of ability to understand or express speech, caused by brain	F 679	R1 and R15 activity care plans have been updated to include goals, participation, and interventions to meet identified needs. A care plan audit was completed on December 22 for all residents who are dependent on staff for assistance with activities. Goals and interventions were updated as needed to ensure individual leisure needs are identified for all like residents. Education will continue to be provided to the IDT including clinical and therapeutic recreation staff on an ongoing basis regarding reviewing, following and providing activities per resident's plan of care. Therapeutic program director has	1/10/18

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F 679	Continued From page 26 damage) stroke and schizoaffective disorder. R1 activities Care Area Assessment (CAA) dated 8/23/17, indicated a potential problem for activities related to R1's inability to communicate and a native language of Arabic. The analysis indicated R1 was unable to perform and do many things at this time due to his lack of communication. Family indicated he did not previously participate in any activities and needed his rest. The CAA indicated a care plan was to be developed as R1 was at risk complications and decline due to lack of ability to communicate activity needs and desires and therapeutic recreation department would provide R1 with a stimulating environment. The CAA did not indicate what types of stimulation or activities would be provided to R1. R1's Therapeutic Recreation Evaluation dated 8/14/17, indicated R1 was a very social person, attended church and enjoyed traveling. The assessment indicated R1 was withdrawn, and had a poor attention span and did not address how the facility would provide activities or stimulation for R1. R1's care plan dated 11/10/17, indicated R1 had altered socialization due to the inability to communicate. Goals for R1 included R1 would continue daily independent activities in his room and participate in short one on one weekly visits. Interventions included providing R1 with with stimulating music, television and other activities. R1's Activity Participation Review dated 11/16/17, indicated R1 was limited in his activities due to cognitive and physical status. The review indicated therapeutic recreation staff and nursing assistants had provided R1 with readings of the	F 679	created a weekly participation record for residents who are dependent on staff for assistance with activities. Audits will be completed weekly for 4 weeks of like residents to ensure care plans are being followed and interventions are being implemented. The Therapeutic Program Director or designee will be responsible. QAPI committee will review results and provide redirection or changes when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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F 679	Continued From page 27 Quran (Islamic religious text) on a tablet as well as turning on the television to soccer, wheeling around the facility via wheelchair and family visits during the last quarter. The review indicated R1's activity goals were met. R1's activity documentation indicated the following: 9/17 - R1 had 17 family visits, no other activities were documented. 10/17 - R1 had nine family visits, and three times the window shades were opened for sensory stimulation. 11/17 - R1 had 10 family visits, twice up in the wheelchair in the hall, one time television with the soccer game on, two prayer visits and one music visit. During observations on 11/28/17, from 9:00 a.m. to 2:28 p.m. R1 was lying in bed with the lights on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) services from staff. During interview on 11/28/17, at 2:30 p.m. family member (FM)-A stated when the family visited, on almost a daily basis, R1 was always lying in bed without any music or television. FM-A stated it would be nice if he was up and around people occasionally even if he could not participate in activities. FM-A stated R1 also liked to be outside, weather permitting. During observations on 11/29/17, from 1:00 p.m. to 6:20 p.m. R1 was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) services from staff. During interview on 11/29/17, at 7:43 p.m. nursing assistant (NA)-J stated R1 spent most of his time lying in bed and didn't have music or a television	F 679		

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on for any stimulation.

During observations on 11/30/17, from 6:54 a.m. through 12:37 p.m. R1 was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) services from staff.

When interviewed on 11/30/17, at 12:24 a.m. NA-E stated R1 was always in bed and did not participate in any structured activities. "I feel terrible for him." NA-E was not aware of any activities to provide R1 for any stimulation, other than family visits.

During interview on 11/30/17, at 12:37 a.m. licensed practical nurse (LPN)-D stated R1's family visited about every other day and occasionally when family was here staff would get R1 up in a wheelchair, so family could sit with him. The facility did not get him up in a wheelchair unless family were present and they requested this, as R1 was a fall risk and needed the one on one when up in the wheelchair. LPN-D stated R1 had a lack of stimulation and the social worker talked to family about music preferences and was still searching for ideas for engaging R1.

During interview on 12/1/17, at 8:09 a.m. therapeutic program director (TPD) stated on admission a therapeutic program evaluation was completed which included likes and dislikes. TPD stated the comprehensive assessment was done annually and quarterly a activity participation evaluation was completed. TPD stated she was the only staff member of the activities department and herself and volunteers provided activities to the residents. TPD stated on admission the family

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stated R1 just needed his rest and really didn't have any activity interests. TPD stated she had received a tablet and downloaded the Quran to play for R1 but had only done this once or twice. Staff had also turned on soccer for him once on the television because family said he liked soccer. TPD stated she opened the curtains in his room for stimulation and had just implemented one on one activities with R1 in November. TPD stated it was difficult to find stimulation activities for R1 with little input from the family and no success with an interpreter present as R1 could not speak. TPD stated she had not included occupational therapy to help determine stimulation activities for R1. A care conference was held the day before and the interpreter and family gave some more ideas on music and activity preferences, but added the conversation should have taken place earlier and the facility could have made attempts even without family input.

On 12/1/17, at 8:26 a.m. speech language therapist (SLP) stated R1 was discharged from therapy services on 9/27/17. The focus of therapy was for communication in general, dysphasia (difficulty swallowing) and safety in a wheelchair all of which were not successful. Occupation therapy did not work with R1 in activity/stimulation goals and did not get a referral from the facility to do so.

During interview on 12/1/17, at 10:27 a.m. director of nursing (DON) stated R1 was unsafe to be up in a wheelchair for activities, however; should have his curtains opened and some sort of noise stimulation through the day. DON stated the facility was relying on family to bring in music and did not try various music on their own. DON

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further stated the nursing assistants had not been instructed to provide any structured activities for R1 throughout the day.

The facility policy Therapeutic Recreation dated 7/09, provided a policy statement " It is our mission to promote dignity and worth of each person and we offer a variety of activities of interest to all clients." A policy interpretations and implementation statement of "A monthly activities calendar is developed by the Therapeutic Recreation and distributed to client." The policy did not include any further information.

R15's annual Minimum Data Set (MDS) dated 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living, and activity preferences were identified by the resident. The MDS identified R15's preferences of books, newspaper, music, animals, news, being with group of people, important favorite activities, going outside and religious services were all not very important.

During observation on 11/28/17, at 10:08 a.m. R15 was in bed smiling, the television was on watching show Oceans 11, able to communicate with yes and no response but was inconsistent with these responses. At 12:05 p.m. he was in the dining room waiting for his meal to be served.

In an interview on 11/28/17, 4:15 p.m. family member (F)-A stated (R15) liked football, basketball, tennis as he was always a big sports fan and knew a lot of sports trivia. He liked all sports, and his favorite sports were hockey and then football. F-A stated the facility should put the television on any sports channel, so he can watch

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these. They were unsure if R15 attended any activities, they usually don't see him in activities when they visit him, but think the facility does some things with him.

During interview on 11/29/17, at 12:41 p.m. therapeutic program director (TPD) stated R15 participated in bingo, social events, and came out for movies. He was limited because of dialysis, but liked the MN Wild hockey and MN Vikings. She was unsure what his assessment identified but would check. At 6:58 p.m. TPD stated the maintenance director fixed R15's television, he brought from home. The television only had five channels on it, now that it was reprogrammed he was able to get the channels the facility offered which included all the sports channels.

R15 was observed on 11/29/17, at 5:56 p.m. at the nurses station waiting for his medication and had a Twins t-shirt on. Licensed practical nurse (LPN)-D stated R15 liked the MN Vikings and R15 smiled at LPN-D. R15 remained out of his room either by the nursing station or in the middle of the hallway until 8:04 p.m. when he was brought to his room to go to bed. There were no activities occurring during this time of day. Once R15 went to bed NA-A turned the television on to an evening program, but did not turn the TV to a sports channel.
During observation on 11/30/17, 7:48 a.m. R15 was waiting for his breakfast and at 8:08 a.m. NA-F was feeding him without difficulty. At 8:45 a.m. R15 was placed in bed and NA-G stated he liked soap operas, cartoons and sports. She has seen him in bingo but not a lot he liked to watch television. NA-G was unaware R15's television channels had been reprogrammed so R15 could watch sports. NA-G turned the television on, and

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made no attempt to look for a sports channel. The television remained on a news program. NA-G stated he liked television and left the room. R15 remained in his room until the lunch meal was served, and had the same television station on. Staff made no attempts to change the television station to a sports channel for R15.
Review of R15's care plan print date 12/1/17, did not have any information about activity goals or participation.
Review of the facility MHM Activity Participation Review, dated 10/2/17, identified under the attendance and participation summary the resident has joined group activities infrequently such as meals in the dining room, snack cart and current events. Resident enjoyed independent activities such as watching TV and sports. Resident attended dialysis three times a week which limited participation. Resident's favorite activities were identified as preferring visits from family and independent activities. Resident enjoyed watching sports. Resident was proud of being a military veteran. The activity plan review identified the plan remained appropriate/current as per care plan, goal was met and interventions were effective in reaching goal.
The facility had a Leisure Request Form, undated, that identified R15 was interested in music all types and in parenthesis Christian, spiritual, viewing sports which include Vikings, Wild and Twins. Does computer games/lesson, reading, writing, pets and animals. The form also identified his past hobbies of going out to eat, Frisbee gold, throwing a foot ball.
The activity participation forms from August 2017, to November 2017, identified activities that R15 was involved in:
8/17: meals 13 days, TV/radio: 9 days and was hospitalized 13 days

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F 679	Continued From page 33 9/17: meals 19 days; conversation 2 days, TV/radio: 19 days; exercise 1 day; spiritual visits 1 day 10/17: meals 22 days; social events 2 days; TV 22 days, spiritual visits 4 days. Refused participation in games, 4 days; currents events; 2 days and social event 1 day 11/17: meals 18 days, music 1 day; social event 1 day; TV/radio 18 days, spiritual visits 3 days. Refused games 4 days and refused current events 1 day. Review of the data identified R15 spent most of his days watching television, and was only involved in 13 days of other events that included spiritual visits, social events, and exercise from August to November 2017, 111 days. During interview on 12/1/17, 11:41 a.m. TPD stated they did a quarterly review of his activity participation before his care conference, and an annual evaluation under section F of the MDS. On a monthly basis his participation was tracked, and the check mark for meals means he was at meals and there was music on which was counted as an activity for R15. She stated R15 was limited due to his dialysis being three times a week. TPD was unaware of the facility Leisure Request Form, she did not know this had been used in the past. R15 received no 1:1 visits from activities, but did have pastoral visits. TPD stated they have not incorporated 1:1 into R15's program, since she was the only person in the facility that did activities for all the residents but needs to look into this for R15. She was unsure of what R15's activity goals were or how this was measured. She also stated she did not tell other staff about the channels being programmed to R15's television so he could watch sports. The TPD forgot to communicate this to staff and was unaware staff was not turning his TV station to	F 679		

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F 679	Continued From page 34 sports. Although R15 was dependent upon staff, and was unable to physically participate in activities without staff assistance, the facility had not completed a comprehensive assessment of R15's activity needs or care plan interventions to meet those needs.	F 679		
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 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 residents with current pressure ulcers were turned and repositioned timely for 1 of 3 residents with pressure ulcers. Findings include: R15's annual Minimum Data Set (MDS) dated 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living, was at risk for	F 686	Resident R15 care plan has been specifically updated to reflect every 2 hour repositioning. Clinical staff have been re-educated. All residents, including new admits, will continue to be provided care and repositioning as care plan reflects. All residents skin plan of care, including repositioning schedules have been audited as of December 26 and reflect specific positioning frequencies and skin	1/10/18

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F 686	Continued From page 35 pressure ulcer (PU) development, and had a current stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed). The MDS indicated R15 received treatments of pressure reduction devices in chair, bed and was on a hydration program and PU treatment program. During continuous observation on 11/29/17, from 5:56 p.m. to 8:04 p.m., R15 was not repositioned timely. At 5:56 p.m. R15 had just finished his evening meal and was sitting at the nursing station watching others while waiting for his medications. Licensed practical nurse (LPN)-D was preparing the medications and talking about sport to R15. At 6:09 p.m. R15 remained sitting in his chair waiting for the nurse and remained there until 6:26 p.m. when LPN-A wheeled R15 to his room for medication administration via tube feeding and was wheeled back to the nursing station at 6:37 p.m. without being repositioned. He remained in his wheelchair at the nursing station until 7:27 p.m. when asked by nursing assistant (NA)-A if he wanted to go to bed. R15 did not respond. NA-A wheeled R15 half way down the hallway and left him in the hallway. NA-A brought a mechanical lift into R15's room and then left again while R15 remained sitting in the hallway. At 7:29 p.m. he was wheeled back to the nursing station and left. He remained there until 7:41 p.m. when he was again wheeled half way down the hallway and left in the hallway. He remained in the hallway while staff walked by, assisting other residents and passing out evening snacks. At 8:04 p.m. registered nurse (RN)-A wheeled R15 into his room and motioned NA-A to assist the resident to bed. With a mechanical lift RN-A and NA-A provided personal cares. R15 was incontinent of bowel and bladder his buttocks	F 686	care needs to prevent and/or heal skin impairments/ulcers, per current assessments. All clinical staff will be re-educated on all resident's current skin plan of care, including repositioning schedules and to follow the resident specific care plan. Audit of repositioning will be done weekly x 4 weeks and then as needed. Director of Nursing or designee will be responsible. QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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F 686	Continued From page 36 were pink. There was an indentation on his coccyx where the PU was located which was approximately .2 cm in size with pink tissue surrounding the area. NA-A stated he was incontinent of small amount of urine and bowel movement. RN-A stated the PU looked good, was very small and had been improving. During interview following cares at 8:46 p.m. NA-A stated R15 was last repositioned around "4:00 ish", then stated he was repositioned around 7:00 p.m., then stated it was "around 4:00 p.m.", more than 4 hours ago. She further stated he should be turned and repositioned every two hours. Review of the facility's undated Team 4 sheets, which were used by the nursing assistants to provide care and is part of the facility care plan, identified R15 needed assistance with toileting every 2 hours, but there was no indication of how frequently R15 needed to be turned and repositioned even though he had a current pressure ulcer. R15's care plan print date 12/1/17 identified R15 was at risk for PU development and had a history of stage 3 and 2 pressure ulcers with a current stage 2 PU on his coccyx. Staff was directed to conduct weekly skin assessments, provide pressure reducing cushion in chair, and bed, apply barrier cream after incontinence, toilet plan and turn and reposition schedule per assessment. R15's pressure ulcer care area assessment dated 10/13/17, indicated R15 had a stage 2 PU to right gluteal, seen by wound nurse practitioner, treatment per order, air mattress to bed. Resident was incontinent of bowel and bladder, needed assistance with turning and repositioning. Braden scale (scoring system to determine risk level for PU) identified a moderate risk for further	F 686		

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F 686	Continued From page 37 breakdown. Although the care plan and assessment identified R15 was to be turned and repositioned per assessment, the frequency of this was not identified. Review of R15's weekly skin notes from 10/17, to 11/28/17, identified R15 had a stage 2 PU located on his coccyx was improving in size. On 11/28/17, the note identified the PU measured .2 centimeters in size and staff were to monitor R15's right lower buttocks near his brief line. During interview on 11/30/17, at 2:00 p.m. LPN-E stated R15's care plan was not specific for a turning and repositioning schedule but it should be. During interview on 12/1/17, at 12:35 p.m. the above information was reviewed with the director of nursing, who indicated they needed to follow a turning and repositioning schedule for (R15).	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	F 688		1/10/18

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F 688	Continued From page 38 receives appropriate services, equipment, and assistance to maintain or improve mobility with 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 provide hands splints and a nursing rehabilitation functional maintenance program for 1 of 2 resident (R15) in the sample who had limited range of motion. Findings include: R15's annual Minimum Data Set (MDS) dated, 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living (ADL's), no upper or lower extremity impairments, had no rejection of cares and there was no mention of a nursing rehabilitation program. Review of the facility Team #4, nursing assistant sheets (form that identified what cares to provide for each resident), undated, identified R15's ADL's were "Right hand splint on when in bed, off in AM [morning]." There was no mention of any nursing rehabilitative program on the sheet. During observation on 11/29/17, at 8:04 p.m. R15 was wheeled into his room by registered nurse (RN)-A and motioned nursing assistant (NA)-A to help assist with personal cares. NA-A washed R15 face, while washing his face R15 was turning his face away and using his left hand to push NA-A away. R15 did not raise his right hand which continued to lay in his lap. R15 made no attempts to move his right hand. RN-A gave R15 a stuffed animal to hold with his left hand and	F 688	Resident R15 is provided a functional range of motion program as recommended by therapy to include a splint to be applied at bedtime and removed in the morning. R15 care plan updated to reflect range of motion program, splint use, and activity goals, participation and interventions implemented to meet identified needs. All residents will continue to be offered any maintenance program as recommended by therapy. Audit of therapy record and nursing has been completed to ensure that they are included in the plan of care. Nursing staff will follow recommendation and re approach and/or document refusals. Process has been implemented to improve therapy to nursing communication. Nursing will continue to provide proper ROM. Education will be completed with therapy and clinical staff regarding the newly revised communication process to include nurse manager initially receiving all therapy communications and ensuring plan of care is developed and followed. Audit will be completed by director of nursing or designee weekly x 4 and as needed. During this audit, nursing will	

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F 688	Continued From page 39 also held R15's left hand to keep R15 from pulling on his incontinent brief. R15 made no attempts to move his right hand which continued to lay in his lap. After cares were completed at 8:45 p.m. RN-A and NA-A left the room. They made no attempts to provide any range of motion, nor did they place a splint on R15's right hand. During interview at 8:46 p.m. NA-A stated the resident did not have any nursing rehab program but had a splint that went on his right hand which the night shift was responsible for. During observation on 11/30/17, at 6:49 a.m. R15 was up and dressed ready for the day. NA-F stated she got R15 up and provided personal cares. She had to hold his left hand because he pushed them away during cares. NA-F stated R15 was supposed to have a splint on his right hand, but he did not have it on this morning when she arrived to work. Review of R15's Occupational Therapy (OT) note, dated 9/26/16, identified R15 had right hemiparesis (paralysis right side of body) with trace movement of his right fingers, no active range of motion in elbow or shoulder, and PROM within functional limited with verbalization of pain when should flexion past 140 degrees. Review of a Therapy Communication form dated, 10/31/16, identified R15 to apply right hand splint at hour of sleep and remove to clean hand with morning cares. The facility Therapy Communication form, dated 12/1/16, identified functional maintenance program (FMP) provide ROM to right upper extremity twice a day, five repetitions to shoulder, elbow and wrist.	F 688	collaborate with therapy and ensure recommendation are current on care plan, point of care, and nursing assistance are guides. QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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F 688	Continued From page 40 The OT discharge summary, dated 12/2/16, identified nursing to continue right upper extremity ROM, and right hand splinting schedule on at night and off during the day. Review of R15's occupational therapy note, 9/25/17, identified bilateral upper extremity passive range of motion (PROM) within functional limits. Limited range of motion related to hemiparesis/brain injury. Nursing reports R15 was on a functional maintenance program (FMP) for PROM in place from previous therapy in nursing care plan. The physical therapy note dated 10/3/17, identified a FMP was in place and to continue the program, R15 has not changed or declined. R15's care plan, print date 12/1/17, identified a problem with physical functioning related to mobility impairment, but did not address the use of a right hand splint or any restorative nursing program. Review of the facility treatment administration record (TAR) from 9/17, through 11/17, did not identify any range of motion, or any hand splint identified as part of the record. During interview on 12/1/17, at 8:13 a.m. certified occupational therapy assistant (COTA)-A stated she was unaware if R15 had any FMP PROM program or if he had any hand splints. During interview on 12/1/17, at 11:23 a.m. LPN-E stated she has never seen a hand splint on the resident. He had blue boots but no splints and has never heard that (R15) received any range of	F 688		

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F 688	Continued From page 41	F 688		

motion (ROM). She stated there were no directions on the medication or treatment records or care plan for the hand splint or ROM.

During interview on 12/1/17, 11:27 a.m. NA-H stated the resident had a hand splint, but did not wear it anymore. NA-I stated R15 had a right hand splint, and went into his room, and located the splint in the top drawer of his night stand. He wore the splint at night, but this morning he did not have it on, nor did he have it on on Tuesday (12/28/17) morning when she took care of him. Frequently he did not have it on when she worked. Evenings are suppose to place it on him when he went to bed, but this frequently did not occur.

During interview on 12/1/17, 12:13 p.m. Director Physical Therapy (DPT) stated he reviewed the therapy notes for R15. Based on the notes and documentation, R15 was on a functional maintenance program with PROM on 3/16/17. The last therapy note on 10/3/17, identified he was still on a FMP with PROM and had a splint to right hand. DPT stated the therapy department created a FMP and nursing was to follow this program. If they had questions or they wanted to change the FMP they needed to consult with therapy. There was no mention that R15's FMP or splinting program had been stopped so he should still be receiving this.

On 12/1/17, at 12:35 p.m. director of nursing (DON) stated she was aware R15 had a right hand splint, but did not know R15 had a FMP PROM program and needed to look into this. The DON reported R15's care plan did not identify the right hand splint or the FMP PROM program which should be included as part of the care plan.

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the facility and dialysis center had coordinated dialysis care for monitoring dialysis site for 1 of 1 resident (R15) in the survey sample who received hemodialysis. Findings include: R15's annual Minimum Data Set (MDS) dated, 10/2/17, identified R15 had severe cognitive impairment, needed extensive to total assistance for activities of daily living and had no behaviors for rejection of cares. The face sheet, undated, identified a diagnosis of end stage renal disease and receiving hemodialysis. R15 was observed on 11/29/17, in his bed resting at 2:45 p.m. and had just returned that afternoon from hemodialysis. At 8:04 p.m. R15 and nursing assistant (NA)-A and registered nurse (RN)-A were assisting R15 with personal cares before bedtime. NA-A stated they placed a clean t-shirt on the resident every night underneath his gown. This prevents him from pulling at the dialysis catheter tubing which he has accidentally pulled out. R15 had a central subclavian line used for dialysis, on his left clavicle, the ports of the catheter were wrapped with kerlix gauze. The dialysis site, had an approximately 4 inch by 4	F 698	R15 dialysis plan of care/TAR has been updated to reflect increased daily dialysis site monitoring during care by the nursing assistants and every 4 hours with the completion of changing the dressing as needed to prevent further dislodgement. The Estates at Twin Rivers will continue to follow dialysis recommendation surrounding the appropriate dressing to use with R15 to prevent infection. All current dialysis centers being used were called on 12/29/17 with no identified concerns. Bi-weekly calls have been sit up with R15's dialysis center and the facility to ensure sustainment of the solutions implemented. All residents, including admits, with dialysis treatment will continue to be provided care that will be coordinated with the dialysis center. Verbal communication will be made routinely with all other dialysis centers should concerns or gaps in service occur. Communication worksheets that include pre and post assessment and dialysis updates/orders, will be sent with all residents receiving dialysis and will be reviewed upon their return to the facility. All dialysis centers	1/10/18

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F 698	Continued From page 43 inch clear dressing over the site. The bottom edge of the dressing had rolled up approximately 1 inch but the dressing was still intact to the skin. While NA-A and RN-A, were assisting R15 with cares, they encouraged him to hold a stuffed animal with his left hand or they held R15 left hand during cares. RN-A, confirmed the edge of the dressing was rolled up but still intact. NA-A stated the dressing got changed daily and when he went to dialysis. Review of R15's facility treatment administration record (TAR) for November 2017 through March 2017, directed staff to check dressing on R15's Central Venous Catheter (CVC) left upper chest each shift to ensure dressing is over the site. If dressing falls off, use sterile technique with a mask on patient and nurse. Do not get wet. This intervention was started on 3/29/17. Review of the Dialysis/Nursing Communication Form from March to November 2017, identified the following: 11/13/17 "Patient removed catheter dressing, reapply if needed." 10/18/17 "Please makes sure dialysis cath is covered at all times. We are aware [R15] pulls dressing off, but to reduce possibility of infection to keep covered." 7/27/17 "Resident is removing dialysis site dressing." The Fresenius Medical Care form, undated, identified under significant events at dialysis, "Pt [patient] came to dialysis cath [catheter] bleeding." 5/29/17 "Please replace catheter drsg [dressing] if it comes off, 3 island drsg sent for you to cover up exit sites of catheter to prevent infection."	F 698	have again been made aware of this continued process. All resident's dialysis plan of care have been audited and site monitoring needs and care have been identified with appropriate interventions in place. Re-education will be provided to the clinical team on overall dialysis care, site care and daily dialysis procedures including retrieval of communication worksheet. Nurses have been re-educated on ensuring R15 has his dialysis site properly dressed per the orders, remain with a shirt on and holding fidget relief items in his hands to prevent self removal/tampering of the dressing as needed. DON and/or designee will monitor process and ensure proper communication with dialysis. If communication form is not filled out by dialysis center, attempts will be made to contact to obtain information to ensure continuity of care. Dialysis site monitoring to include random visual inspections of R15. Completion of communication worksheet by dialysis center and facility audits will be completed weekly x 4 weeks. QAPI committee will review results and provide redirection or change when necessary and dictate continuation or complete of this monitoring process based on compliance date.	

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F 698	Continued From page 44	F 698		

5/15/17 "Site should be always be covered with sterile dressing (should it inadvertently come loose, it must be covered.)"
3/29/17 "I sent cath dressing w [with] if falls off. apply sterile technique with mask on pt [patient] and staff. We will try other dressing today to see if it will stick better. Do not get wet."
During interview on 12/1/17, at 10:46 a.m. the Fresenius Dialysis RN-E stated R15 was currently at the dialysis center for a run. RN-E stated the resident had problems with infections at other various sites, so it was important for the nursing home to monitor R15's central line dressing. She stated R15 comes from the nursing home to the dialysis center, with his central line dressing, either not on, or not secured very well. RN-E stated, today his dressing was just hanging and R15 was pulling at it. This has been communicated with the nursing home but it continued to be an ongoing problem. They used a communication form that was sent to and from the dialysis center and nursing home for coordination and communication needs.
On 12/1/17, at 11:08 a.m. licensed practical nurse (LPN)-E stated R15's dressing was on when she checked it before he left this morning. If the dressing comes off, we clean it and replace it. She has never had to replace R15's dialysis site dressing before, and had not heard any concerns from the NA about his dressing this morning.
During interview on 12/1/17, at 11:27 a.m. NA-H and NA-I both stated they took care of R15 this morning, and noticed the dressing on his central line was peeling and almost off. NA-I stated the only area that was sticking to his skin was an approximately 50 cent size area just around the insertion site of the catheter. She told the nurse in passing about it this morning, was unsure if the nurse heard it, but she did tell her.

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F 698	Continued From page 45 The above information was discussed with the director of nursing on 12/1/17, at 12:30 a.m. who stated they needed to monitor this more closely. The Long Term Care Facility Outpatient Dialysis Services Agreement effective 4/1/2016 identified the parties will mutually develop a written protocol for the development and implementation of a resident's care plan relative to the provision of dialysis services. The nursing facility will provide for the interchange of information useful or necessary for the care of the resident and will inform the ESRD Dialysis Unit who is responsible for the oversight of dialysis services.	F 698		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this	F 757		1/10/18

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F 757	Continued From page 46 section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure adequate monitoring was completed for 1 of 3 resident (R2) who received blood glucose monitoring. Finding include: R2's annual Minimum Data Set (MDS) dated 11/17/17, identified R2 had moderate cognitive impairment and diagnosis of diabetes (high blood sugar levels). R2's undated physician Order Summary Report updated 10/27/17, identified Lantus 8 units/milliliters (long acting insulin) subcutaneous every morning and a sliding scale of insulin Aspart (fast-acting insulin) based on R2's blood glucose levels. The scale ranged from 2 unit of Aspart insulin for blood glucose of 150-199 milligram/deciliter (mg/dl) up to 10 units for blood glucose levels over 350 mg/dl. Review of R2's lab report dated 11/1/17, identified R2's A1C (measures glycated hemoglobin) was high at 6.2, (normal range 4-5.6). The physician order dated 11/21/17, identified R2's blood glucose monitoring was changed from four times a day to once a day due to resident refusals. The order also identified to monitor R2's blood glucose levels every morning and if R2's morning glucose levels are less 75 mg/dl and greater than 300 mg/dl to contact the physician. Review of the facility November 2017 medication and treatment records identified R2's blood glucose level monitoring at 7:00 a.m. The form	F 757	Resident R2 had blood glucose level added to order to prompt nursing documentation of levels. All residents, including admits, will have proper documentation of ordered vital signs or medication administration. Medication reconciliation for all residents has been completed. Nurses will be re-educated on order transcribing with return demonstration of the ability to successfully transcribe 5 orders or more if needed. All orders will continue to be double checked by a licensed nurse. Medication reconciliation will continue to occur upon admit/re-admit and as needed with changes. Medication administration record and/or treatment administration record will be audited for accuracy of order transcription and appropriate documentation of supplementary data including results levels and values (ie blood pressure, blood glucose, vital signs, etc.) on 5 random residents weekly x 4 and as needed thereafter. Random MAR and TAR audits will remain on an ongoing basis as needed. DON and/or designee will be responsible party.	

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F 757	Continued From page 47 identified check marks with staff initials. There was no indication of what R2's blood glucose levels were from 11/21/17 until current 12/1/17. During interview on 11/30/17, at 1:51 PM Trained Medication Assistant (TMA)-A stated they check R2's blood glucose levels every morning, and was unsure why blood glucose levels were missing since the change of physician orders on 11/21/17. TMA-A stated she can check R2's blood glucose machine to see what the levels were since 11/21/17. Review of R2's machine identified various dates of 12/1 and 12/4. The machine was not set with accurate dates and TMA-A was unable to determine what R2's blood sugars had been. TMA-A stated it was important to know R2's levels because the physician wanted to be notified if R2's blood glucose level was over 300 mg/dl and lower than 75 mg/dl. On 11/30/17, at 1:58 PM licensed practical nurse (LPN)-C stated the person who changed the physician's order should have added an area in the computer system so blood glucose levels could be placed to monitor. The nurses should have communicated this concern to each other. During interview on 11/30/17, at 2:11 p.m. health unit coordinator (HUC)-A reviewed R2's blood glucose monitoring system and stated any nurse can add this to the computer system and should have when they first noted this was missing. R2's glucose levels were not monitored for 10 days.	F 757	QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	
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	F 880		1/10/18

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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 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

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F 880	Continued From page 49 (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 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 observation, interview and document review the facility failed to ensure proper handwashing and glove usage was implemented for 1 of 5 residents (R15) observed for personal cares. In additional the faciltiy lacked a water management program for the prevention of legionella, which had the potential to affect all 43 residents, along with staff and visitors. Findings include: HANDWASHING and GLOVE R15 was observed during personal cares on	F 880	NA-A was re-educated on infection control in relation to hand washing and glove use, with hand hygiene skill demonstrated. The facility has established a water management program for prevention of legionella. R15 and all residents, including admits, are receiving appropriate personal cares with the use of appropriate PPE to prevent the spread of infections based on universal precautions. All clinical staff and other pertinent	

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F 880	Continued From page 50 11/29/17, at 8:04 p.m. when registered nurse (RN)-A wheeled R15 into his room and motioned nursing assistant (NA)-A to assist the resident to bed. NA-A and RN-A assist R15 using a mechanical lift to transfer him from the wheelchair into bed. Once in bed NA-A removed the sling placed gloves on and washed R15's legs with a washcloth. NA-A removed R15 incontinent product, which was soiled with urine then washed R15's perineal area. She removed her gloves and without washing her hands donned a new pair of gloves and continued to provide peri care with a disposable cloth. R15 had a small bowel movement which NA-A cleaned. When finished NA-A used the same soiled gloves and placed an incontinence brief on R15, touching R15's pillow, adjusting his gown, bedding and placed his feet on a pillow without removing the soiled gloves. NA-A continued with the same soiled gloves and placed heel protectors on R15, picked up R15's soiled clothing and opened the bathroom door. She washed R15's basin and placed the basin in the drawer of R15's nightstand, then removed the soiled gloves. During interview on 11/29/17, at 8:46 p.m. after R15's cares were completed, NA-A was unaware she did not change her soiled gloves or wash her hands between glove usage. The above information was discussed with the director of nursing on 12/1/17, at 12:30 a.m. , no additional information was provided. Review of the facility policy entitled, Handwashing, undated, identified procedure B: Indication for Hand Hygiene/Handwashing were identified as; before and after direct contact with resident, after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressing and after removing gloves.	F 880	departments will receive re-education on proper use of personal protective equipment, including glove use to prevent infection and demonstrate hand hygiene competency. All staff will received education on the water management program to prevent legionella. Audit of resident personal cares with the use of appropriate PPE will be completed weekly x 4 weeks and as needed thereafter. Director of Nursing or designee will be responsible. QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.	

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F 880	Continued From page 51	F 880		

LACK OF WATER MANAGEMENT PROGRAM FOR FOR LEGIONELLA PREVENTION
On 11/30/17, at 2:41 p.m., the director of nursing (DON) stated she was in charge of the infection control program, especially the day-to-day surveillance and tracking of resident infections in the facility. The DON knew the facility "had a policy" regarding preventing the spread of Legionella, but stated she was not aware of the water management assessment, or the mechanics of the facility's monitoring of the water system to prevent the potential start or spread of Legionella. The DON stated the facility had no current Legionella-related pneumonia infections.

A facility policy, Legionella Water Management Program, undated, indicated Legionella infections can cause a serious type of pneumonia (Legionnaire's Disease) in persons at risk, and that outbreaks have been linked to poorly maintained water system in building with large or complex water systems, including hospitals and long-term care facilities. The policy indicated the Water Management Program included key elements:

- conducting a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread;
- implementing a water management program including control measures, inspections and environmental testing for pathogens; and
- testing protocols, acceptable ranges of control measures, documentation of results and corrective actions taken when control limits are not maintained.

A Center for Disease Control (CDC) document,

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F 880	Continued From page 52 Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 6/5/17, indicated Legionnaire's disease was a serious type of pneumonia caused by bacteria, called Legionella that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. Implementing a water management program can reduce a building's risk for growing and spreading Legionella. When interviewed on 12/1/17, at 11:07 a.m., the facility administrator stated the facility "did not have" a formal water management program in response to Legionella. The administrator stated there was a corporate policy in place, and the facility did the first part of the CDC "toolkit" assessment, which determined the need for a water management plan, and there were also some bath cleaning policies. The administrator stated the facility had not completed a full assessment, or analyzed the building's water supply and tubs, or had a monitoring plan. The administrator stated we need a program and "we are working toward it." A facility policy, Infection Prevention and Control Program, dated 8/17, indicated important facets of infection prevention included "following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).	F 880		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at	F 912		1/10/18

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F 912	Continued From page 53 least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 80 square feet of floor space per resident in 8 of 28 resident rooms (room#s 4, 7, 17, 20, 21, 29, 35 and 36) which affected 13 residents (R38, R240, R8, R10, R9, R141, R25, R26, R2, R4, R3, R90, R23) who currently resided in these rooms. The following double resident rooms did not meet the required minimum square footage per resident: Room 4 = 150 square feet, or 75 square feet per resident, (R38) Room 7 = 152.5 square feet, or 76.25 square feet per resident, (R240 and R8) Room 17 = 150 square feet, or 75 square feet per resident, (R10) Room 20 = 150 square feet, or 75 square feet per resident, (R9 and R141) Room 21 = 150 square feet, or 75 square feet per resident, (R25 and R26) Room 29 = 150 square feet, or 75 square feet per resident, (R2 and R4) Room 35 = 150 square feet, or 75 square feet per resident, (R3) Room 36 = 155 square feet, or 77.5 square feet per resident, (R90 and R23)	F 912	The Estates at Twin Rivers would like to request a waiver under F912 regarding resident room size. The rooms to be included in this waiver are 4, 7, 17, 20, 21, 29, 35, and 36. These rooms were constructed in 1962 and do not meet the current requirements for square footage in multiple resident rooms. There is no method available to increase the size of the rooms without causing hardship to the facility. Granting this waiver would not adversely affect the residents residing in the identified rooms. The resident's health, treatments, comfort, safety and wellbeing will be maintained at the highest possible level. Currently, there are no concerns or complaints regarding their room size. The Director of Maintenance is responsible for monitoring of this waived requirement.	

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F 912	Continued From page 54 Room 4 Room was currently being used as a private room, for R4, but has the potential to occupy two residents, no concerns identified. Room 7 During interview on 11/30/17, at 12:19 a.m. R240, stated she did not have enough room in her room and she was very claustrophobic, but was working with the social worker to be transferred to a larger room. During interview on 12/1/17, at 11:48 a.m. R8, who resided in Room 7 stated she had enough room for the items she needed in her room. Room 17 During interview on 11/28/17 at 4:15 p.m. R10 stated she had no issues. She wished it could be a little larger and the facility has offered her a room change, but she likes this room. Room 20 In an interview on 12/01/17 12:58 p.m. R141 stated he just got back for the hospital from when he was admitted on Tuesday and had no issue with his room size. R9 who was in the room was unable to express his preference. Room 21 During an interview on 12/01/17 12:58 p.m. R25 stated he had no concerns about the room size. R26 was hospitalized, and not available. Room 29 R4's quarterly MDS, dated 8/18/17 indicated he independent with activities of daily living (ADLs) and had fully intact cognition.	F 912		

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R2's quarterly MDS, dated 8/18/17 indicated he was independent with ADLs and was moderately, cognitively impaired.

During observation on 11/28/17 at 2:10 p.m., room #29 was set up with two resident beds, with a hanging curtain dividing the room. To the right of the room door was a night stand, upon which was a TV. Next to the night stand was a bed, positioned lengthwise along the adjacent wall. R4 was in the room, seated in a wheel chair and watching TV. On the other side of the divider curtain was a recliner, the back of which was against the wall, at the foot of the first bed. Immediately next to the recliner was the second bed, positioned lengthwise next to the window. R2, seated in the recliner, was dozing off, watching his TV, which was on top a small stand located about 6 feet in front of him.

During interview on 11/28/17 at 2:23 p.m. R2, who lived in room #29, stated he had been in the facility for "some time" and "I can get the care I need." R-2 stated the room space was tight, and you just had to keep the space clean. R2 stated staff were good about "keeping space free and clear" and added his room space "was OK."

During interview on 11/28/17 at 3:38 p.m. nursing assistant (NA)-D stated "we manage" with in the smaller rooms, "its small, no doubt." NA-D stated she had been doing this for more than three years, and you just have to move things around first. NA-D stated that although the rooms were small, there was "nothing" we can't get done for the residents.

When interviewed on 11/29/17 at 2:15 p.m. NA-E

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stated when providing cares in the small room, you had to do "some organizing" and have on hand, and within reach, what you need to do the cares. NA-E stated dong the cares was about learning to manage the space you have, and also that it required "a lot of patience." NA-E denied not being able to provide cares in the smaller rooms, like room #29.

When interviewed on 11/29/17 at 2:30 p.m. R4, who lived in room 29 stated the room was "kinda small." R4 questioned how much more space was needed, and stated "It would be nice" to have a little more room. R4 denied having any difficulty in getting cares done, and stated he had "no concern" as to the room size.

During interview on 12/1/17 at 8:10 a.m., LPN-E stated although she would not want to live in a tiny room, resident rooms were organized to keep the main walkway into the room "clear," and when providing cares to residents, you use the privacy curtains. LPN-E stated doing cares maybe was "a little inconvenient," but staff worked to get them done.

Room 35:
During observation on 11/28/17 at 11:00 a.m. room 35 had two single beds with bedside stands. There were no wheelchair or other resident equipment in the room.

R3 quarterly MDS dated, 8/24/17, identified R3 had moderate cognitive impairment, and needed extensive staff assistance with ADL's. During interview on 11/28/17 at 11:00 a.m. R3 was in bed, and stated she had no concerns regarding her room size and was the only resident who lived

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in room 35.

Room 36
During observation of room 36 on 11/28/17 at 11:23 a.m. there were two single beds with bedside stands and one wheelchair. There was no other care equipment identified in the room.

R23's quarterly MDS dated, 10/24/17, identified R23 had intact cognition, was independent with ADL's, needed staff assistance with set up only and independent with ambulation. During interview on 11/28/17 at 11:23 a.m. R23 stated she doesn't need any staff help and plans to discharge soon. She had no concerns with her room size and was able to maneuver independently without any concerns.

R90 was interviewed on 11/28/17 at 10:00 a.m. and stated she was just admitted to the facility a few days ago and uses a wheelchair in her room. She stated she was able to maneuver in her room without any problems. The size of the room was small, but she did not have any concerns about the size.

During interview on 11/30/17 at 8:56 a.m. NA-F stated she had no problems with maneuvering equipment or residents in room 35 or 36. They keep residents whom are more independent in these rooms. The rooms are small but she had been there for so many years she knows how to move equipment and residents around in these rooms.

When interviewed on 12/1/17 at 8:44 a.m., the director of nursing (DON) stated "we try to accommodate" the residents' needs in the waiver

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F 912	Continued From page 58 rooms, and stated the room size comes up every year. The DON stated prior to admission, residents are offered a tour and are shown the rooms, then asked if they would like it, especially if the resident will be staying long-term. The DON stated residents' needs were considered when assigning to available rooms. The DON stated if a resident required a mechanical lift, a bariatric bed, or a large oxygen canister, for example, they would avoid placing him or her in a small room. The DON stated if resident was not happy with the smaller room, or any room, "we would offer" to re-arrange the current room to the resident preference or, following protocol, offer the resident a different room. The DON stated the smaller rooms did not mean staff were unable to complete resident cares. The DON also stated that if there were concerns about room size in the future, the facility would address those issues as needed. The facility's request for a continuing waiver of the following health deficiency(ies) has been forwarded to the CMS Region V Office for its determination. F-912 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LAST 80 SQ FT/RESIDENT. Approval of the waiver request has been recommended.	F 912		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 921		1/10/18

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to ensure the kitchen was kept clean, sanitary and in good repair which had the potential to affect all 43 residents who received meals from the kitchen.

Findings include:

During observation of the kitchen on 11/28/17, at 9:15 a.m. with the Culinary Services Manager (CSM), a certified dietary manager, and the facility registered dietitian (RD)-A identified they fed 43 residents from the kitchen, the following items were noted:

A kitchen garbage can located near the hand washing sink had a a lid, that was covered in dirt, dust, debris and had a dried gray substances splashed on the lid. The external can also had dirt, dust, debris that was dried on the outside of the garbage can.

Near the hand washing sink was a four wheeled metal cart that had a base of an Oster Black and Decker blender along with other kitchen appliances on the cart that were covered with dust, crumbs and dried debris. The three shelves of the metal cart were also covered with crumb, dust and debris.

Through out the kitchen, the floor had an accumulation of various debris, dirt, crumbs and a sticky residue that stuck your shoes to the floor in front of the refrigerator. The area was approximately four feet in diameter. Under the refrigerator, carts, stoves, cook and prep area there was a heavy accumulation of visible

F 921

The areas of concern identified were addressed by culinary services and maintenance staff. The entire kitchen has been thoroughly cleaned to provide a clean and sanitary environment. The process has been initiated regarding repair to the flooring and walls in the kitchen.

Culinary services staff have been re-educated on facility polices and procedures for cleanliness of the kitchen and equipment.

Audits will be completed weekly x 4 weeks and then as needed to ensure kitchen cleanliness.

The Culinary Service Manager or designee will be responsible.

QAPI committee will review results and provide redirection or change when necessary and dictate continuation or completion of this monitoring process based on compliance date.

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F 921	Continued From page 60 crumbs, dirt and debris under all of these areas. There was a visible heavy build up of dirt and debris that was black in color located under the wheels and legs of the portable prep station, and refrigerator. There was a stainless steel three shelf chart, near the prep station with dried food, and debris splashed on the sides and lateral supports of the cart, along with dirt, crumbs and debris on the shelves of the cart. CSM stated they used this for transporting food items in and out of the kitchen. There was baseboard missing near the entryway of the dry storage area. The area was approximately 8 inches long by 4 inches long, and exposed the dry wall behind the baseboard. There was a plastic three shelf cart in the dry storage area, that was full of dust, crumbs and debris on each of these shelves. CSM identified this was used for transporting food, and other items in the kitchen or to residents in the facility. The dishwasher had a heavy white, cloudy residue on the outside. There was a heavier build up of this white substance on the four corner supports of the dishwasher. The facility produce refrigerator had visible crumbs and food debris throughout the bottom of the refrigerator. The chest freezer had a various crumbs on the bottom of the freezer, that had not been cleaned. The refrigerator/freezer located in the serving room, had shelves with a build up of crumbs, debris and a sticky dried substance. The freezer	F 921		

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F 921	Continued From page 61	F 921		

had a heavy build of various creamy color sticky substances dried on the shelves. There were individual resident ice cream cups in the freezer. Outside on the refrigerator/freezer door there was brown, black colored debris on the bottom and edges of the refrigerator and freezer door, along with the same substance under the handles of the refrigerator and freezer.

During kitchen tour on 11/30/17, at 9:25 a.m. the following items were identified:

The window above the three compartment sink had visible dirt, debris and cob webs. The sink had a heavy white build up across the top of the sink, and around the faucets and faucet handles.

Inside the two storage units where pots, pans, lids and plastic containers were stored, the shelves had visible debris. The sliding door tracks had crumbs, debris and a brown substance in the tracking making it difficult to close the cupboard sliding doors. There were three plastic bins, that had a white build up on the sides, and under the handles had visible brown debris. Inside the two baking oven there was dried food, and crumbs on the bottom. There was a heavy build up of brown debris on the top and edges of the oven doors that could be scraped off with a fingernail.

The dish room had 12, 12x12 floor tiles in the dishwashing area and under the dishwasher. The tile corners were broken off, worn and had multiple large spider type cracks that extended the length and width of the 12x12 tiles. Other tiles had large cracks through the entire width of the tile. Under the dishwasher was a heavy build up of yellow, and tan color debris. Under the clean dish racks located next to the wall had an area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING ___ B. WING ___	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	305 FREMONT STREET ANOKA, MN 55303

(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 921		F 921		

Continued From page 62
approximately 6 inch by 2 foot long of a slimy tan colored substance. The dish racks had a heavy build up of a white visible substance. The wall between the dish room and kitchen area had 4, 4x4 inch white tiles missing. There was a linoleum piece in this area between the baseboard and wall not attached to the wall. Behind the linoleum was a hole in the wall. Across the wall in the dish area the tiles were splattered with a tan, brown substance approximately 8 feet long and 4 feet high. Lying against this wall were five clean dish racks.

Review of the daily cleaning schedules identified thirteen plus areas for daily cleaning of the floors, wipe off all carts, clean and wipe off all shelves, stoves, ovens, wipe down and clean coffee area. The bottom of the form identified, "Failure to complete daily cleaning may result in disciplinary action."

Review of the facility shift cleaning schedules from October 30 to November 26, 2017 identified 81 of 112 shifts cleaning were left blank.

During interview on 11/30/17 at 10:03 a.m. RD-A and CSM both stated they knew the kitchen needed some more work, and cleaning. They have been busy with staffing and the CSM has also been working in the kitchen as well. They just need more oversight, and we will make these changes.

Review of the Monarch Cleaning schedule policy, undated, identified each facility will be maintained in a clean, sanitary condition. The Department Director is responsible to provide and post the cleaning scheduled in their department. Each employee is responsible to know their assigned

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	245298	A. BUILDING ______ B. WING ______	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	**305 FREMONT STREET** **ANOKA, MN 55303**

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F 921	Continued From page 63 duty, and to carry it out during their work shift. Each employee is responsible to document in the specified area for their completed duty. Cleanliness will be maintained through regular cleaning.	F 921		

Printed: 12/13/2017

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

F5298027

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	**305 FREMONT STREET ANOKA, MN 55303**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 29, 2017. At the time of this survey, The Estates at Twin Rivers was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Estates at Twin Rivers is a 1-story building with a partial basement was built in 1962 with an addition in 1977 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 41 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Electronically delivered December 18, 2017

Ms. Becky Willett, Administrator
The Estates at Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5298029

Dear Ms. Willett:

The above facility was surveyed on November 28, 2017 through December 1, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the 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 Unit Supervisor Brenda Fischer at brenda.fischer@state.mn.us or (320) 223-7338.

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 related to this electronic notice.

Sincerely,

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: ____ B. WING ____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	**305 FREMONT STREET ANOKA, MN 55303**

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2 000	Initial Comments	2 000		

*****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

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2 000	Continued From page 1	2 000		

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 11/28/17 through 12/1/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: ______ B. WING ______	12/01/2017

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2 000	Continued From page 2 PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review the faciltiy failed to ensure comprehensive care plans were developed for range of motion (ROM), splints and activities for 1 of 7 residents (R15) who were dependent upon staff for activities of daily living and rehabilitation. Findings include: ROM AND SPLINTS R15's annual MDS, 10/2/17, identified R15 had no upper or lower extremity impairments, no rejection of cares and was not involved in a nursing rehabilitation program. Review of R15's Occupational Therapy (OT) note, 9/26/16 identified R15 had right hemiparesis (paralysis right side of body) with trace movement of his right fingers, no active range of motion in elbow or shoulder, and PROM within functional	2 560	corrected	1/10/18

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2 560	Continued From page 3	2 560		

Continued From page 3

limited with verbalization of pain when should flexion past 140 degrees.

The Therapy Communication form dated, 10/31/16, identified for nursing to apply right hand splint to R15 at hour of sleep and remove with morning cares and clean his hand.

Review of the facility Therapy Communication form, dated, 12/1/2016, identified functional maintenance program (FMP) provide ROM to right upper extremity twice a day, five repetitions to shoulder, elbow and wrist.

The occupational therapy (OT) discharge summary, 12/2/16, identified nursing to continue right upper extremity ROM, and right hand splinting schedule on at night and off during the day.

Review of R15's occupational therapy note, 9/25/17 identified bilateral upper extremity passive range of motion (PROM) within functional limits. Limited range of motion related to hemiparesis/brain injury. Nursing reports (R15) on functional maintenance program (FMP) for PROM in place from previous therapy in nursing care plan.

The physical therapy note 10/3/17 identified a FMP was in place and to continue the program, (R15) has not changed or declined.

R15's care plan, print date 12/1/17, identified a problem with physical functioning related to mobility impairment, but did not address the use of a right hand splint or any restorative nursing program as part of the care plan.

Review of the facility treatment administration

Minnesota Department of Health

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2 560		2 560		

Continued From page 4

record (TAR) from September 2017 through November 2017, did not identify any range of motion, or any hand splint identified as part of the TAR.

Review of the facility Team #4, nursing assistant sheets, a form used by nursing assistants identified under R15's ADL's were "Right hand splint on when in bed, off in AM [morning]." There was no mention of any nursing rehabilitative program on this sheet.

During interview on 12/01/17 12:13 p.m. Director Physical Therapy (DPT) stated R15 was on a functional maintenance program with PROM on 3/16/17 and the last therapy note on 10/3/17 identified he was still on that program and a splint to right hand. There was no mention that R15 FMP or splinting program had been stopped and he should still be receiving this as identified in the therapy notes.

In an interview on 12/01/17 12:35 p.m. director of nursing (DON) stated she was aware (R15) had a right hand splint, but did not know (R15) had a FMP PROM program. The DON reported R15's care plan did not identify the right hand splint or the FMP PROM program which should be included as part of the care plan.

ACTIVITIES
R15's annual Minimum Data Set (MDS) dated, 10/2/17 identified R15 had severe cognition, needed extensive to total assistance for all activities of daily living, and activity preferences were identified by the resident. The MDS identified R15's preferences of books, newspaper, music, animals, news, being with group of people, important favorite activities,

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2 560	Continued From page 5	2 560		

going outside and religious services were all not very important.

Review of the faciltiy MHM Activity Participation Review, dated 10/2/17 identified under the attendance and participation summary. The resident has joined group activities infrequently such as meals in the dining room, snack cart and current events. Resident enjoys impendent activities such as watching TV and sports. Resident does attend dialysis three times a week which limits participation. Resident's favorite activities as identified as he prefers visits form family and independent activities. Resident enjoys watching sports. Resident if proud of being a military veteran. and the activity plan review identified the plans remain appropriate/current as per care plan, goal were met and interventions were effective in reaching goal.

Review of R15 care plan print date, 12/1/17, did not have any information about activity goals, participation or interventions implemented to meet R15's activity needs.

During interview on 12/01/17 11:41 a.m. Therapeutic recreation director (TRD) stated they do a quarterly review of his activity participation before his care conference, and then an annual evaluation under section F of the MDS. On a monthly basis we track his participation. She was unsure of what R15's activity goals were or how this was measured on the care plan.

Although R15 was dependent upon staff, and was unable to physically participate in activities without staff assistance, the facility had not completed a comprehensive care plan to meet his activity needs.

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2 560	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures related to the development of the care plans to ensure appropriate care is provided. Education could be provided to the staff and a system to monitor for compliance could be developed. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for activities, oral care and shaving facial hair for 3 of 5 residents (R39, R15 and R1) reviewed who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: ACTIVITIES R1's admission Minimum Data Set dated 8/17/17, indicated R1 had no speech and was rarely understood and had moderately severe depression.	2 565	corrected	1/10/18

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2 565	Continued From page 7 R1 care plan dated 11/10/17, indicated R1 had altered socialization due to the inability to communicate. Goals for R1 included R1 would continue daily independent activities in his room and participate in short one on one weekly visits. Interventions included providing R1 with with stimulating music, television and other activities. During observations on 11/28/17, at 9:00 a.m. to 2:28 p.m. R1 was lying in bed with the lights on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) from staff. During interview on 11/28/17, at 2:30 p.m. family member (FM)-A stated R1 when the family visited, on almost a daily basis) R1 was always lying in bed without any music or television. During observations on 11/29/17, at 1:00 p.m. to 6:20 p.m. R1 was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) from staff. During interview on 11/29/17, at 7:43 p.m. nursing assistant (NA)-J stated R1 spent most of his time lying in bed and didn't have music or a television on for any stimulation. During observations on 11/30/17, at 6:54 a.m. through 12:37 p.m. was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) from staff. During interview on 12/1/17, at 10:27 a.m. director of nursing (DON) stated R1's current	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 8	2 565		

care plan should be followed.

ORAL CARE
R39's diagnoses, as identified on the annual Minimum Data Set (MDS) assessment dated 9/27/17, included cognitive, social or emotional deficit following cerebral vascular disease (stroke) and left hemiplegia, and also indicated R39 required extensive assistance of staff to complete ADLs. The MDS also indicated R39 had intact cognition. R39's care plan, revised 7/12/17, identified R39 had a physical functioning deficit, but was able to brush teeth after set up.

During observation on 11/30/17 beginning at 6:51 a.m., licensed practical nurse entered R39's room to take his blood sugar. After getting the blood sugar, LPN briefly exited the room and provided R39 with some milk and jelly to eat in response to the lower blood sugar. At 8:22 a.m., licensed practical nurse (LPN)-A entered R39's room to re-check a blood sugar, and left the room when nursing assistant (NA)-B greeted R39 to begin morning cares. NA-B gathered care supplies, towels and clothing and began R39's morning routine. NA-B washed and dressed R39, then placed a lift sling under R39. Using a mechanical lift, and with assistance of NA-E, NA-B transferred R39 from the bed into the wheelchair. NA-B groomed R39's face, combed his hair, and asked R39 if there was anything else he needed, to which R39 shook his head. During this morning routine, NA-B did not offer or provide any oral cares for R39. NA-B told R39 she would take him to breakfast, then exited the room carrying the bagged, soiled items from the room. Upon return to the room at 8:44 a.m., NA-B transported R39 into the dining room for breakfast, again without offer of oral cares.

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Following breakfast at 9:43 a.m., NA-B wheeled R39 back to his room, where R39 expressed wanting to remain in the wheel chair and watch TV. NA-B adjusted the TV and headphones to R39's likings, placed the call light on the wheel chair and exited R39's room. Again there was no provision nor offer to provide oral cares to R39 following breakfast. R39 remained in his chair until after he was assisted to eat the noon meal in his room at 12:08 p.m.

When interviewed on 11/30/17 at 12:30 p.m., NA-b stated she had lots of residents to assist this morning and missed to offer R39 oral cares. " I just forgot to offer tooth brushing." She stated that (R39) was dependent upon staff to complete his oral cares.

During interview on 11/30/17 at 1:02 p.m., LPN-A stated the care plan should be followed and R39 should be offered and assisted as need to do his teeth. LPN-A stated staff need to try, and try more than once if needed, and added R39's teeth brushing "should have been done."

When interviewed on 12/1/17 at 8:49 a.m., the director of nursing (DON) stated oral cares should be at least offered in the morning and evening to all residents. The DON stated she expected oral cares needed to be offered to residents, not forced, but if refused, to re-approach or have another caregiver try. The DON stated staff were to offer oral cares "at least twice daily."

SHAVING
R15's annual Minimum Data Set (MDS) dated, 10/2/17 identified R15 had severe cognition, needed extensive to total assistance for all activities of daily living, and had no rejection of

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2 565	Continued From page 10	2 565		

cares.

R15's care plan print date 12/1/17 identified R15 was physical functioning deficit related to self care impairment and ability with ADL's can vary. Staff were directed to provide personal hygiene assistance of one.

R15 was observed on 11/28/17 10:08 a.m. in his bed watching television, he was unable to communicate and had visible facial hair. On 11/29/17 5:56 p.m. R15 was at nursing station unshaven with visible facial hair. On 11/30/17 at 6:49 a.m. R15 was in his wheelchair and dressed for the day. He was unshaven and had visible facial hair approximately 1/8 inch long. At 12:30 p.m. R15 was in bed watching television with visible facial hair and had not been shaven for the past few days. On 12/01/17 at 8:58 a.m. R15 continued to be unshaven with visible facial hair and left for dialysis at approximately 10:00 a.m. unshaven.

During interview on 12/01/17 11:08 a.m. licensed practical nurse (LPN)-E stated they were responsible for (R15's) shaving and the nursing assistants (NA's) are suppose to do this, whenever he has "lots of beard." At 11:10 a.m. NA-H who was R15's NA for the day stated she shaves (R15) when he is "scruffy." I was going to shave him today but dialysis come and got him. They do not shave him every day, only when it is needed because he pulls away when we try to shave him. During this time NA-G stated she took care of him on Thursday (11/30/17) and she did not shave him because he doesn't like his face touched.

Review of the facility Point Of Care form identified one person physical assistance with personal

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2 565	Continued From page 11 hygiene that included shaving. Review of the documentation from 11/18/17 to 12/1/17 had check marks in place for both days and evening shifts which identified personal hygiene was completed for R15. In an interview on 12/01/17 12:35 p.m. director of nursing (DON) stated staff are to follow the point click care documentation when providing cares to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/revise policies and procedures related to the implementation of the care plans to ensure appropriate care is provided. Education could be provided to the staff and a system to monitor for compliance could be developed. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		1/10/18

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 2 of 3 residents (R1, R25) reviewed for accidents, 1 of 3 (R15) residents reviewed for pressure ulcers, 1 of 3 residents (R34) reviewed for incontinence, and 1 of 5 residents (R26) reviewed for medication.

corrected

Findings include:

ACCIDENTS
R25 had the diagnoses of alcohol-induced persisting dementia and cirrhosis of the liver, nicotine dependence, essential hypertension and anemia identified on the facility undated face sheet. The annual minimum data set (MDS), dated 10/20/17, indicated R25 was cognitively intact and require limited assistance with activities of daily living (ADLs). The Care Area Assessment (CAA) for ADLs indicated R25 needed assistance with ADLs, this resident did not liked being helped, and the assistant level varied from day to day.

R25 was observed returning back inside after smoking on 11/29/17 at 6:27 p.m.. R25 was noticed not to have any clothing or shin burns. R25 stated he is not supervised nor adaptive equipment such as a smoking apron.

During a medication pass observation on 11/30/17 at 8:10 a.m., R25 asked licensed practical nurse (LPN)-A for two cigarettes, which were stored in the medication cart. While observing R25 smoke, resident did not display any unsafe smoking behaviors. LPN-A stated the facility holds R25's cigarettes in the medication

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cart and has 3 times a day he smokes where he is given 2 cigarettes each time. LPN-A stated that (R25) was independent with smoking and doesn't wear a smoking apron.

In review of R25's smoking assessments, entitled: MHM Smoking Evaluation, last assessed 10/24/17, the facility indicated: "Resident is independent with smoking. Resident has had a issues once or twice in the past 3-4 months of accidentally dropping his cigarette, however no concerns at present." In further review of previous assessments, dated 8/24/17, R25 needed supervisor, and the assessment dated 3/23/17, indicted R25 needed a smoking apron. There was no mention for the use of a smoking apron on the 10/24/17 assessment.

Review of R25's care plan (initiation date of 11/03/15), indicted: "At risk for smoking related injury related to: Smokes with supervision. The Goal indicated: "I will have no smoking related injuries." The interventions included: that the facility would "observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources..." and that the facility would "provide smoking apron while smoking."

During an interview on 11/30/17 at 12:10 p.m., the director or nursing (DON) stated the facility is still "supervising R25 with his smoking, even if they are not outside, while they are holding on to his cigarettes." The DON stated the smoking apron was no longer worn due to resident refusals.

R1's admission Minimum Data Set dated 8/17/17, indicated R1 had no speech and was rarely understood and had moderately severe depression. The MDS indicated R1 needed total

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assistance to transfer and extensive assistance with locomotion on the unit. Diagnoses included aphasia (loss of ability to understand or express speech, caused by brain damage) stroke and schizoaffective disorder. The MDS indicated R1 had two or more falls without injury since admission.

R1's care plan dated 11/10/17, indicated R1 was at risk for falls and indicated a concave mattress was in place.

During observation on 11/29/17, at 6:00 p.m. R1 was lying in a bariatric sized bed without a concave mattress.

During interview on 11/29/17, at 7:43 p.m. NA-J stated R1 used to have a concave mattress but his mattress was replaced with a larger bed. NA-J did not know when the mattress was replaced.

During interview on 12/1/17, at 10:27 a.m. DON stated R1's concave mattress was replaced with a bariatric bed as R1 moves a lot in bed, and thought that would help prevent falls. DON stated care plan should have been revised to reflect current interventions.

Documentation on when the mattress was changed was requested and was not received.

PRESSURE ULCERS
R15's annual Minimum Data Set (MDS) dated, 10/2/17 identified R15 had severe cognition, needed extensive to total assistance for all activities of daily living, was at risk for pressure ulcer (PU) development, and a current stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed). R15 received treatment of pressure reductions

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devices in chair, bed and was on a hydration program and PU treatment program.

R15's pressure ulcer care area assessment, 10/13/17 indicated R15 has a stage 2 PU to right gluteal, seen by wound nurse practitioner, treatment per order, air mattress to bed. Resident was incontinent of bowel and bladder, needs assistance with turning and repositioning. Braden scale (scoring system to determine risk level for PU) was 14 (moderate risk) risk for further breakdown. Although the assessment identified for R15 was turned and repositioned, but the frequency was not identified.

R15's care plan print date 12/1/17 identified R15 was at risk for PU development and had a history of stage 3 and 2 pressure ulcers with a current stage 2 PU on his coccyx. Staff were directed to conduct a weekly skin assessments, provide pressure reducing cushion in chair, and bed, apply barrier cream after incontinence, toilet plan and turn and reposition schedule per assessment. Although the assessment identified there was a turning and repositioning schedule, this was not added to the care plan.

During interview on 11/30/17 at 2:00 p.m. LPN-E stated (R15's) care plan was not specific for a turning and repositioning schedule and it should be.

MEDICATIONS
R26 had the diagnoses of chronic congestive heat failure (CHF), major depression, chronic pain, chronic kidney diease, anemia, and essential hypertension, undated facility face

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2 570	Continued From page 16	2 570		

sheet. The quarterly Minimum Data Set (MDS), dated 11/03/17, indicated R26 was cognitively intact and require staff set up and limited assistance with toileting.

R26 was admitted to the hospital during the first day of survey (11/28/18) and returned to the facility the last day of survey (12/01/17).

In review of R26's care plan (initiated dated of 8/03/17), it was noted that the facility had identified the two following concerns for monitoring medication:

1. "The resident in on Anticoagulant therapy Coumadin (a blood thinner) r/t [related to: diease process of DVT [deep vein thrombosis], pulmonary embolism [blood clots to the lungs]." The intervention section directed staff to monitor sign and symptoms of bleeding, and medications to avoid.

2. "Potential for psychotropic drug ADR's [adverse drug reactions] r/t [related to] daily use of psychotropic medication. Receives Cymbalta (an antidepressant) for the diagnosis of depression." The staff were directed to being tapering the medication for discontinuation, and update the MD (physician/PA (physician assistant) regarding efficiency of the medication.

In review of R26's physician's orders, dated 10/26/17, there was no indication that R26 was receiving either Coumadin or Cymbalta. In further review, it was documented that the facility received an order on 8/15/17 to decrease the Cymbalta to 60 milligrams (mg) everyday, and that it was OK to discontinue this medication after 2 week if symptoms do not return. The facility received an order on 10/11/17 to discontinue the

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2 570	Continued From page 17 Coumadin medication. During interview on 12/01/17 at 8:30 a.m., the director of nursing (DON) stated that R26's care plan was not revised after the discontinuation of both the Coumadin and Cymbalta medications. A policy on care plan revisions was requested and was not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. A system to monitor for compliance could be developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure shaving was provided for 1 of 5 residents (R15) in the sample	2 850	corrected	1/10/18

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2 850	Continued From page 18 who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R15's annual Minimum Data Set (MDS) dated, 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living, and had no rejection of cares. R15's care plan print date 12/1/17, identified R15 had a physical functioning deficit related to self care impairment and ability with ADL's can vary. Staff was directed to provide personal hygiene assistance of one. R15 was observed on 11/28/17, at 10:08 a.m. in his bed watching television, he was unable to communicate and had visible facial hair. On 11/29/17, at 5:56 p.m. R15 was at nursing station unshaven with visible facial hair. On 11/30/17, at 6:49 a.m. R15 was in his wheelchair and dressed for the day. He was unshaven and had visible facial hair approximately 1/8 inch long. At 12:30 p.m. R15 was in bed watching television with visible facial hair and had not been shaved for the past few days. On 12/1/17, at 8:58 a.m. R15 remained unshaven with visible facial hair and left for dialysis at approximately 10:00 a.m. unshaven. During interview on 12/1/17, at 11:08 a.m. licensed practical nurse (LPN)-E stated they were responsible for (R15's) shaving and the nursing assistants (NA's) are suppose to do this, whenever he has "lots of beard." At 11:10 a.m. NA-H who was R15's NA for the day, stated she shaves [R15] when he is "scruffy." I was going to shave him today but dialysis come and got him.	2 850		

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2 850	Continued From page 19 They do not shave him every day, only when it is needed because he pulls away when we try to shave him." During this time NA-G stated she took care of him on Thursday (11/30/17) and she did not shave him because he doesn't like his face touched. Review of the facility Point Of Care form identified one person physical assistance with personal hygiene which included shaving. Review of the documentation from 11/18/17, to 12/1/17, identified check marks were in place for both days and evening shifts which identified personal hygiene was completed for R15. On 12/1/17, at 12:35 p.m. director of nursing (DON) stated staff was to follow the point click care documentation when providing cares to residents. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures related to ensuring staff provide the necessary grooming services for shaving residents and educate staff on these policies. A system to monitor for compliance could be developed. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 850		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 855		1/10/18

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2 855	Continued From page 20 E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral cares were offered or provided for 2 of 5 residents (R39, R15) in the sample who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R39's diagnoses, as identified on the annual Minimum Data Set (MDS) assessment dated 9/27/17, included cerebral vascular disease (stroke) with left hemiplegia, and identified R39 required extensive assistance of staff to complete ADLs. The MDS also indicated R39 had intact cognition. A care area assessment (CAA) for ADLs, dated 9/27/16, indicated R39 required assistance with dressing, grooming and bathing. The care plan, revised 7/12/17, identified R39 had a physical functioning deficit, but was able to brush teeth after set up. On 11/30/17, at 6:51 a.m., a licensed practical nurse (LPN) checked R39's blood sugar in his room. The LPN then provided R39 with some milk and jelly to eat in response to the blood sugar. At 8:22 a.m., LPN-A entered R39's room to re-check the blood sugar, and left the room when nursing assistant (NA)-B greeted R39 to begin morning cares. NA-B gathered care supplies, towels and clothing and began R39's morning routine. NA-B washed and dressed R39, then placed a lift sling under R39. Using a mechanical	2 855	corrected	

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2 855	Continued From page 21 lift and with assistance of NA-E, NA-B transferred R39 from the bed into the wheelchair. Once seated and adjusted, NA-B groomed R39's face, combed his hair, and asked R39 if there was anything else he needed, to which R39 shook his head. During this morning routine, NA-B did not offer or provide any oral cares for R39. NA-B told R39 she would take him to breakfast, then exited the room carrying the bagged, soiled items from the room. Upon return to the room at 8:44 a.m., NA-B transported R39 into the dining room for breakfast, again without offer of oral cares. Following breakfast at 9:43 a.m., NA-B wheeled R39 back to his room, where R39 expressed wanting to remain in the wheel chair and watch TV. NA-B adjusted the TV and headphones to R39's preference, placed the call light on the wheel chair and exited R39's room. There was no provision or offer of oral cares for R39. R39 remained in his chair until after he was assisted to eat the noon meal in his room at 12:08 p.m. On 11/30/17, at 12:30 p.m., NA-B stated she had lots of residents to assist this morning and did not offer R39 oral cares stating, "I just forgot to offer tooth brushing." NA-B also stated R39 was dependent upon staff to complete his cares. During interview on 11/30/17, at 1:02 p.m., LPN-A stated the care plan should be followed and R39 should be offered and assisted as need to do his teeth. LPN-A stated staff need to try, and try more than once if needed. LPN-A added R39's teeth brushing "should have been done." When interviewed on 12/1/17 at 8:49 a.m., the director of nursing (DON) stated at a minimum, oral cares should be offered in the morning and evening. The DON stated she expected oral	2 855		

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2 855	Continued From page 22 cares needed to be offered to residents. If refused, staff should reapproach or have another caregiver attempt cares. A facility document, Oral Hygiene, dated 2/15, identified the purpose of the [Oral Care] procedure was to clean and freshen resident's mouth, remove food particles form between teeth, to maintain the teeth and gums in a healthy condition, to prevent infections of the mouth and to keep the resident's lips and oral tissues moist. The Policy directed staff to offer oral hygiene as indicated on the resident's plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate direct care staff regarding expectations for oral hygiene. The DON or designee could develop auditing systems to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 855		
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	2 895		1/10/18

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2 895	Continued From page 23	2 895		

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 provide hands splints and a nursing rehabilitation functional maintenance program for 1 of 2 resident (R15) in the sample who had limited range of motion.

corrected

Findings include:

R15's annual Minimum Data Set (MDS) dated, 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living (ADL's), no upper or lower extremity impairments, had no rejection of cares and there was no mention of a nursing rehabilitation program.

Review of the facility Team #4, nursing assistant sheets (form that identified what cares to provide for each resident), undated, identified R15's ADL's were "Right hand splint on when in bed, off in AM [morning]." There was no mention of any nursing rehabilitative program on the sheet.

During observation on 11/29/17, at 8:04 p.m. R15 was wheeled into his room by registered nurse (RN)-A and motioned nursing assistant (NA)-A to help assist with personal cares. NA-A washed R15 face, while washing his face R15 was turning his face away and using his left hand to push NA-A away. R15 did not raise his right hand which continued to lay in his lap. R15 made no attempts to move his right hand. RN-A gave R15 a stuffed animal to hold with his left hand and

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2 895	Continued From page 24	2 895		

also held R15's left hand to keep R15 from pulling on his incontinent brief. R15 made no attempts to move his right hand which continued to lay in his lap. After cares were completed at 8:45 p.m. RN-A and NA-A left the room. They made no attempts to provide any range of motion, nor did they place a splint on R15's right hand. During interview at 8:46 p.m. NA-A stated the resident did not have any nursing rehab program but had a splint that went on his right hand which the night shift was responsible for.

During observation on 11/30/17, at 6:49 a.m. R15 was up and dressed ready for the day. NA-F stated she got R15 up and provided personal cares. She had to hold his left hand because he pushed them away during cares. NA-F stated R15 was supposed to have a splint on his right hand, but he did not have it on this morning when she arrived to work.

Review of R15's Occupational Therapy (OT) note, dated 9/26/16, identified R15 had right hemiparesis (paralysis right side of body) with trace movement of his right fingers, no active range of motion in elbow or shoulder, and PROM within functional limited with verbalization of pain when should flexion past 140 degrees.

Review of a Therapy Communication form dated, 10/31/16, identified R15 to apply right hand splint at hour of sleep and remove to clean hand with morning cares.

The facility Therapy Communication form, dated 12/1/16, identified functional maintenance program (FMP) provide ROM to right upper extremity twice a day, five repetitions to shoulder, elbow and wrist.

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The OT discharge summary, dated 12/2/16, identified nursing to continue right upper extremity ROM, and right hand splinting schedule on at night and off during the day.

Review of R15's occupational therapy note, 9/25/17, identified bilateral upper extremity passive range of motion (PROM) within functional limits. Limited range of motion related to hemiparesis/brain injury. Nursing reports R15 was on a functional maintenance program (FMP) for PROM in place from previous therapy in nursing care plan.

The physical therapy note dated 10/3/17, identified a FMP was in place and to continue the program, R15 has not changed or declined.

R15's care plan, print date 12/1/17, identified a problem with physical functioning related to mobility impairment, but did not address the use of a right hand splint or any restorative nursing program.

Review of the facility treatment administration record (TAR) from 9/17, through 11/17, did not identify any range of motion, or any hand splint identified as part of the record.

During interview on 12/1/17, at 8:13 a.m. certified occupational therapy assistant (COTA)-A stated she was unaware if R15 had any FMP PROM program or if he had any hand splints.

During interview on 12/1/17, at 11:23 a.m. LPN-E stated she has never seen a hand splint on the resident. He had blue boots but no splints and has never heard that (R15) received any range of motion (ROM). She stated there were no directions on the medication or treatment records

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2 895		2 895		

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or care plan for the hand splint or ROM.

During interview on 12/1/17, 11:27 a.m. NA-H stated the resident had a hand splint, but did not wear it anymore. NA-I stated R15 had a right hand splint, and went into his room, and located the splint in the top drawer of his night stand. He wore the splint at night, but this morning he did not have it on, nor did he have it on on Tuesday (12/28/17) morning when she took care of him. Frequently he did not have it on when she worked. Evenings are suppose to place it on him when he went to bed, but this frequently did not occur.

During interview on 12/1/17, 12:13 p.m. Director Physical Therapy (DPT) stated he reviewed the therapy notes for R15. Based on the notes and documentation, R15 was on a functional maintenance program with PROM on 3/16/17. The last therapy note on 10/3/17, identified he was still on a FMP with PROM and had a splint to right hand. DPT stated the therapy department created a FMP and nursing was to follow this program. If they had questions or they wanted to change the FMP they needed to consult with therapy. There was no mention that R15's FMP or splinting program had been stopped so he should still be receiving this.

On 12/1/17, at 12:35 p.m. director of nursing (DON) stated she was aware R15 had a right hand splint, but did not know R15 had a FMP PROM program and needed to look into this. The DON reported R15's care plan did not identify the right hand splint or the FMP PROM program which should be included as part of the care plan.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could

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2 895	Continued From page 27 devise a communication system with the Director of Therapy or designee to ensure communication processes regarding nursing rehabilitation programs. The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing range of motion as directed, and then audit to ensure compliance. 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 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 residents with current pressure ulcers were turned and repositioned timely for 1 of 3 residents with	2 900	corrected	1/10/18

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2 900	Continued From page 28	2 900		

pressure ulcers.

Findings include:

R15's annual Minimum Data Set (MDS) dated 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living, was at risk for pressure ulcer (PU) development, and had a current stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed). The MDS indicated R15 received treatments of pressure reduction devices in chair, bed and was on a hydration program and PU treatment program.

During continuous observation on 11/29/17, from 5:56 p.m. to 8:04 p.m., R15 was not repositioned timely. At 5:56 p.m. R15 had just finished his evening meal and was sitting at the nursing station watching others while waiting for his medications. Licensed practical nurse (LPN)-D was preparing the medications and talking about sport to R15. At 6:09 p.m. R15 remained sitting in his chair waiting for the nurse and remained there until 6:26 p.m. when LPN-A wheeled R15 to his room for medication administration via tube feeding and was wheeled back to the nursing station at 6:37 p.m. without being repositioned. He remained in his wheelchair at the nursing station until 7:27 p.m. when asked by nursing assistant (NA)-A if he wanted to go to bed. R15 did not respond. NA-A wheeled R15 half way down the hallway and left him in the hallway. NA-A brought a mechanical lift into R15's room and then left again while R15 remained sitting in the hallway. At 7:29 p.m. he was wheeled back to the nursing station and left. He remained there until 7:41 p.m. when he was again wheeled half way down the hallway and left in the hallway. He

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2 900	Continued From page 29 remained in the hallway while staff walked by, assisting other residents and passing out evening snacks. At 8:04 p.m. registered nurse (RN)-A wheeled R15 into his room and motioned NA-A to assist the resident to bed. With a mechanical lift RN-A and NA-A provided personal cares. R15 was incontinent of bowel and bladder his buttocks were pink. There was an indentation on his coccyx where the PU was located which was approximately .2 cm in size with pink tissue surrounding the area. NA-A stated he was incontinent of small amount of urine and bowel movement. RN-A stated the PU looked good, was very small and had been improving. During interview following cares at 8:46 p.m. NA-A stated R15 was last repositioned around "4:00 ish", then stated he was repositioned around 7:00 p.m., then stated it was "around 4:00 p.m.", more than 4 hours ago. She further stated he should be turned and repositioned every two hours. Review of the facility's undated Team 4 sheets, which were used by the nursing assistants to provide care and is part of the facility care plan, identified R15 needed assistance with toileting every 2 hours, but there was no indication of how frequently R15 needed to be turned and repositioned even though he had a current pressure ulcer. R15's care plan print date 12/1/17 identified R15 was at risk for PU development and had a history of stage 3 and 2 pressure ulcers with a current stage 2 PU on his coccyx. Staff was directed to conduct weekly skin assessments, provide pressure reducing cushion in chair, and bed, apply barrier cream after incontinence, toilet plan and turn and reposition schedule per assessment. R15's pressure ulcer care area assessment dated 10/13/17, indicated R15 had a stage 2 PU	2 900		

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2 900	Continued From page 30	2 900		

to right gluteal, seen by wound nurse practitioner, treatment per order, air mattress to bed. Resident was incontinent of bowel and bladder, needed assistance with turning and repositioning. Braden scale (scoring system to determine risk level for PU) identified a moderate risk for further breakdown. Although the care plan and assessment identified R15 was to be turned and repositioned per assessment, the frequency of this was not identified.

Review of R15's weekly skin notes from 10/17, to 11/28/17, identified R15 had a stage 2 PU located on his coccyx was improving in size. On 11/28/17, the note identified the PU measured .2 centimeters in size and staff were to monitor R15's right lower buttocks near his brief line.

During interview on 11/30/17, at 2:00 p.m. LPN-E stated R15's care plan was not specific for a turning and repositioning schedule but it should be.

During interview on 12/1/17, at 12:35 p.m. the above information was reviewed with the director of nursing, who indicated they needed to follow a turning and repositioning schedule for (R15).

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff responsible for giving cares/services on following the care plan exactly as directed to promote healing and prevent pressure ulcers from developing. The director of nursing or designee could then conduct audits to ensure care and serves were being followed.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21385	Continued From page 31	21385		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper handwashing and glove usage was implemented for 1 of 5 residents (R15) observed for personal cares. In additional the faciltiy lacked a water management program for the prevention of legionella, which had the potential to affect all 43 residents, along with staff and visitors. Findings include: HANDWASHING and GLOVE R15 was observed during personal cares on 11/29/17, at 8:04 p.m. when registered nurse (RN)-A wheeled R15 into his room and motioned nursing assistant (NA)-A to assist the resident to bed. NA-A and RN-A assist R15 using a mechanical lift to transfer him from the wheelchair into bed. Once in bed NA-A removed the sling placed gloves on and washed R15's legs with a washcloth. NA-A removed R15 incontinent product, which was soiled with urine then washed R15's perineal area. She removed her gloves and without washing her hands donned a new pair of gloves and continued to provide peri care	21385	corrected	1/10/18

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with a disposable cloth. R15 had a small bowel movement which NA-A cleaned. When finished NA-A used the same soiled gloves and placed an incontinence brief on R15, touching R15's pillow, adjusting his gown, bedding and placed his feet on a pillow without removing the soiled gloves. NA-A continued with the same soiled gloves and placed heel protectors on R15, picked up R15's soiled clothing and opened the bathroom door. She washed R15's basin and placed the basin in the drawer of R15's nightstand, then removed the soiled gloves.

During interview on 11/29/17, at 8:46 p.m. after R15's cares were completed, NA-A was unaware she did not change her soiled gloves or wash her hands between glove usage.
The above information was discussed with the director of nursing on 12/1/17, at 12:30 a.m. , no additional information was provided.

Review of the facility policy entitled, Handwashing, undated, identified procedure B: Indication for Hand Hygiene/Handwashing were identified as; before and after direct contact with resident, after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressing and after removing gloves.

LACK OF WATER MANAGEMENT PROGRAM FOR FOR LEGIONELLA PREVENTION
On 11/30/17, at 2:41 p.m., the director of nursing (DON) stated she was in charge of the infection control program, especially the day-to-day surveillance and tracking of resident infections in the facility. The DON knew the facility "had a policy" regarding preventing the spread of Legionella, but stated she was not aware of the water management assessment, or the mechanics of the facility's monitoring of the water

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system to prevent the potential start or spread of Legionella. The DON stated the facility had no current Legionella-related pneumonia infections.

A facility policy, Legionella Water Management Program, undated, indicated Legionella infections can cause a serious type of pneumonia (Legionnaire's Disease) in persons at risk, and that outbreaks have been linked to poorly maintained water system in building with large or complex water systems, including hospitals and long-term care facilities. The policy indicated the Water Management Program included key elements:

- conducting a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread;
- implementing a water management program including control measures, inspections and environmental testing for pathogens; and
- testing protocols, acceptable ranges of control measures, documentation of results and corrective actions taken when control limits are not maintained.

A Center for Disease Control (CDC) document, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 6/5/17, indicated Legionnaire's disease was a serious type of pneumonia caused by bacteria, called Legionella that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. Implementing a water management program can reduce a building's risk for growing and spreading Legionella.

When interviewed on 12/1/17, at 11:07 a.m., the

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facility administrator stated the facility "did not have" a formal water management program in response to Legionella. The administrator stated there was a corporate policy in place, and the facility did the first part of the CDC "toolkit" assessment, which determined the need for a water management plan, and there were also some bath cleaning policies. The administrator stated the facility had not completed a full assessment, or analyzed the building's water supply and tubs, or had a monitoring plan. The administrator stated we need a program and "we are working toward it."

A facility policy, Infection Prevention and Control Program, dated 8/17, indicated important facets of infection prevention included "following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) Days.

21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		1/10/18

(a) A nursing home provider must establish and

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maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the nursing home.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a tuberculosis skin tests (TST) or chest rays were conducted and the results documented for 2 of 5 new employees (NA-K, TMA-B) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention.

Plan of correction: corrected

Findings include:

Nursing assistant (NA)-K's employee record identified NA-K was hired on 9/20/17, and had a symptom screen for TB on 9/20/17. A first and second step TST was completed on 5/4/17 and 5/17/17, was negative with 0 millimeters induration, prior to employment at the facility. The

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director of nursing stated on 11/30/17 at 1:00 p.m. NA-K's TST was completed by a previous employer. She was unaware only one of the TST's counted for TB screening and they needed to complete the second step for the TST, which was not completed.

Trained Medication Assistant (TMA)-B's employee file identified she was hired on 8/1/17, and had a symptom screen for TB on 7/17/17. The form identified TMA-A, was unable to complete a TST because of a previous history of positive TST. There was no indication that TMA-A had a current chest X-ray to identify she was free from TB. The administrator stated on 11/30/17 at 12:40 p.m. that TMA-A did not actually work at the facility and was no longer employed. Review of TMA-A's time sheets from 7/18/17 to 8/31/17 identified TMA-A worked a total of nine evening shifts as a trained medication assistant at the facility.

The facility Tuberculosis Screening Health Care Worker policy, undated, indicated all health care workers will receive baseline TB screening, which includes a written assessment, and a 2 step TST. If the employee has written proof of a negative of TST within 12 months of employment, this will be counted as a 1st step TST. The employee will receive a second step TST one to three weeks from date of hire. If the employee has a history of positive TST, a chest x-ray will be taken and the Health Care Worker- Tuberculosis Screening Form will be completed by a physician.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure tuberculosis screening and testing is done

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21426	Continued From page 37 on all staff according to regulations upon hire. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 2 of 3 residents (R1, R15) who were dependent on staff for activities. Findings include: R1's admission Minimum Data Set dated 8/17/17, indicated R1 had no speech, was rarely	21435	corrected	1/10/18

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21435	Continued From page 38 understood and had moderately severe depression. The staff interview of family about activities indicated there were no activities important to R1. The MDS indicated R1 needed total assistance to transfer and extensive assistance with locomotion on the unit. Diagnoses included aphasia (loss of ability to understand or express speech, caused by brain damage) stroke and schizoaffective disorder. R1 activities Care Area Assessment (CAA) dated 8/23/17, indicated a potential problem for activities related to R1's inability to communicate and a native language of Arabic. The analysis indicated R1 was unable to perform and do many things at this time due to his lack of communication. Family indicated he did not previously participate in any activities and needed his rest. The CAA indicated a care plan was to be developed as R1 was at risk complications and decline due to lack of ability to communicate activity needs and desires and therapeutic recreation department would provide R1 with a stimulating environment. The CAA did not indicate what types of stimulation or activities would be provided to R1. R1's Therapeutic Recreation Evaluation dated 8/14/17, indicated R1 was a very social person, attended church and enjoyed traveling. The assessment indicated R1 was withdrawn, and had a poor attention span and did not address how the facility would provide activities or stimulation for R1. R1's care plan dated 11/10/17, indicated R1 had altered socialization due to the inability to communicate. Goals for R1 included R1 would continue daily independent activities in his room and participate in short one on one weekly visits. Interventions included providing R1 with with	21435		

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21435	Continued From page 39 stimulating music, television and other activities. R1's Activity Participation Review dated 11/16/17, indicated R1 was limited in his activities due to cognitive and physical status. The review indicated therapeutic recreation staff and nursing assistants had provided R1 with readings of the Quran (Islamic religious text) on a tablet as well as turning on the television to soccer, wheeling around the facility via wheelchair and family visits during the last quarter. The review indicated R1's activity goals were met. R1's activity documentation indicated the following: 9/17 - R1 had 17 family visits, no other activities were documented. 10/17 - R1 had nine family visits, and three times the window shades were opened for sensory stimulation. 11/17 - R1 had 10 family visits, twice up in the wheelchair in the hall, one time television with the soccer game on, two prayer visits and one music visit. During observations on 11/28/17, from 9:00 a.m. to 2:28 p.m. R1 was lying in bed with the lights on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) services from staff. During interview on 11/28/17, at 2:30 p.m. family member (FM)-A stated when the family visited, on almost a daily basis, R1 was always lying in bed without any music or television. FM-A stated it would be nice if he was up and around people occasionally even if he could not participate in activities. FM-A stated R1 also liked to be outside, weather permitting. During observations on 11/29/17, from 1:00 p.m. to 6:20 p.m. R1 was lying in bed. The lights were on without any music, television or interaction	21435		

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from staff aside from required care (medications, turning and repositioning) services from staff.

During interview on 11/29/17, at 7:43 p.m. nursing assistant (NA)-J stated R1 spent most of his time lying in bed and didn't have music or a television on for any stimulation.

During observations on 11/30/17, from 6:54 a.m. through 12:37 p.m. R1 was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) services from staff.

When interviewed on 11/30/17, at 12:24 a.m. NA-E stated R1 was always in bed and did not participate in any structured activities. "I feel terrible for him." NA-E was not aware of any activities to provide R1 for any stimulation, other than family visits.

During interview on 11/30/17, at 12:37 a.m. licensed practical nurse (LPN)-D stated R1's family visited about every other day and occasionally when family was here staff would get R1 up in a wheelchair, so family could sit with him. The facility did not get him up in a wheelchair unless family were present and they requested this, as R1 was a fall risk and needed the one on one when up in the wheelchair. LPN-D stated R1 had a lack of stimulation and the social worker talked to family about music preferences and was still searching for ideas for engaging R1.

During interview on 12/1/17, at 8:09 a.m. therapeutic program director (TPD) stated on admission a therapeutic program evaluation was completed which included likes and dislikes. TPD stated the comprehensive assessment was done

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annually and quarterly a activity participation evaluation was completed. TPD stated she was the only staff member of the activities department and herself and volunteers provided activities to the residents. TPD stated on admission the family stated R1 just needed his rest and really didn't have any activity interests. TPD stated she had received a tablet and downloaded the Quran to play for R1 but had only done this once or twice. Staff had also turned on soccer for him once on the television because family said he liked soccer. TPD stated she opened the curtains in his room for stimulation and had just implemented one on one activities with R1 in November. TPD stated it was difficult to find stimulation activities for R1 with little input from the family and no success with an interpreter present as R1 could not speak. TPD stated she had not included occupational therapy to help determine stimulation activities for R1. A care conference was held the day before and the interpreter and family gave some more ideas on music and activity preferences, but added the conversation should have taken place earlier and the facility could have made attempts even without family input.

On 12/1/17, at 8:26 a.m. speech language therapist (SLP) stated R1 was discharged from therapy services on 9/27/17. The focus of therapy was for communication in general, dysphasia (difficulty swallowing) and safety in a wheelchair all of which were not successful. Occupation therapy did not work with R1 in activity/stimulation goals and did not get a referral from the facility to do so.

During interview on 12/1/17, at 10:27 a.m. director of nursing (DON) stated R1 was unsafe to be up in a wheelchair for activities, however;

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should have his curtains opened and some sort of noise stimulation through the day. DON stated the facility was relying on family to bring in music and did not try various music on their own. DON further stated the nursing assistants had not been instructed to provide any structured activities for R1 throughout the day.

The facility policy Therapeutic Recreation dated 7/09, provided a policy statement " It is our mission to promote dignity and worth of each person and we offer a variety of activities of interest to all clients." A policy interpretations and implementation statement of "A monthly activities calendar is developed by the Therapeutic Recreation and distributed to client." The policy did not include any further information.

R15's annual Minimum Data Set (MDS) dated 10/2/17, identified R15 had severe cognition impairment, needed extensive to total assistance for all activities of daily living, and activity preferences were identified by the resident. The MDS identified R15's preferences of books, newspaper, music, animals, news, being with group of people, important favorite activities, going outside and religious services were all not very important.

During observation on 11/28/17, at 10:08 a.m. R15 was in bed smiling, the television was on watching show Oceans 11, able to communicate with yes and no response but was inconsistent with these responses. At 12:05 p.m. he was in the dining room waiting for his meal to be served.

In an interview on 11/28/17, 4:15 p.m. family member (F)-A stated (R15) liked football, basketball, tennis as he was always a big sports fan and knew a lot of sports trivia. He liked all

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sports, and his favorite sports were hockey and then football. F-A stated the facility should put the television on any sports channel, so he can watch these. They were unsure if R15 attended any activities, they usually don't see him in activities when they visit him, but think the facility does some things with him.

During interview on 11/29/17, at 12:41 p.m. therapeutic program director (TPD) stated R15 participated in bingo, social events, and came out for movies. He was limited because of dialysis, but liked the MN Wild hockey and MN Vikings. She was unsure what his assessment identified but would check. At 6:58 p.m. TPD stated the maintenance director fixed R15's television, he brought from home. The television only had five channels on it, now that it was reprogrammed he was able to get the channels the facility offered which included all the sports channels.

R15 was observed on 11/29/17, at 5:56 p.m. at the nurses station waiting for his medication and had a Twins t-shirt on. Licensed practical nurse (LPN)-D stated R15 liked the MN Vikings and R15 smiled at LPN-D. R15 remained out of his room either by the nursing station or in the middle of the hallway until 8:04 p.m. when he was brought to his room to go to bed. There were no activities occurring during this time of day. Once R15 went to bed NA-A turned the television on to an evening program, but did not turn the TV to a sports channel.

During observation on 11/30/17, 7:48 a.m. R15 was waiting for his breakfast and at 8:08 a.m. NA-F was feeding him without difficulty. At 8:45 a.m. R15 was placed in bed and NA-G stated he liked soap operas, cartoons and sports. She has seen him in bingo but not a lot he liked to watch

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television. NA-G was unaware R15's television channels had been reprogrammed so R15 could watch sports. NA-G turned the television on, and made no attempt to look for a sports channel. The television remained on a news program. NA-G stated he liked television and left the room. R15 remained in his room until the lunch meal was served, and had the same television station on. Staff made no attempts to change the television station to a sports channel for R15.

Review of R15's care plan print date 12/1/17, did not have any information about activity goals or participation.
Review of the facility MHM Activity Participation Review, dated 10/2/17, identified under the attendance and participation summary the resident has joined group activities infrequently such as meals in the dining room, snack cart and current events. Resident enjoyed independent activities such as watching TV and sports. Resident attended dialysis three times a week which limited participation. Resident's favorite activities were identified as preferring visits from family and independent activities. Resident enjoyed watching sports. Resident was proud of being a military veteran. The activity plan review identified the plan remained appropriate/current as per care plan, goal was met and interventions were effective in reaching goal.

The facility had a Leisure Request Form, undated, that identified R15 was interested in music all types and in parenthesis Christian, spiritual, viewing sports which include Vikings, Wild and Twins. Does computer games/lesson, reading, writing, pets and animals. The form also identified his past hobbies of going out to eat, Frisbee gold, throwing a foot ball.

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The activity participation forms from August 2017, to November 2017, identified activities that R15 was involved in:
8/17: meals 13 days, TV/radio: 9 days and was hospitalized 13 days
9/17: meals 19 days; conversation 2 days, TV/radio: 19 days; exercise 1 day; spiritual visits 1 day
10/17: meals 22 days; social events 2 days; TV 22 days, spiritual visits 4 days. Refused participation in games, 4 days; currents events; 2 days and social event 1 day
11/17: meals 18 days, music 1 day; social event 1 day; TV/radio 18 days, spiritual visits 3 days. Refused games 4 days and refused current events 1 day.

Review of the data identified R15 spent most of his days watching television, and was only involved in 13 days of other events that included spiritual visits, social events, and exercise from August to November 2017, 111 days.
During interview on 12/1/17, 11:41 a.m. TPD stated they did a quarterly review of his activity participation before his care conference, and an annual evaluation under section F of the MDS. On a monthly basis his participation was tracked, and the check mark for meals means he was at meals and there was music on which was counted as an activity for R15. She stated R15 was limited due to his dialysis being three times a week. TPD was unaware of the facility Leisure Request Form, she did not know this had been used in the past. R15 received no 1:1 visits from activities, but did have pastoral visits. TPD stated they have not incorporated 1:1 into R15's program, since she was the only person in the facility that did activities for all the residents but needs to look into this for R15. She was unsure of what R15's activity goals were or how this was

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21435	Continued From page 46 measured. She also stated she did not tell other staff about the channels being programmed to R15's television so he could watch sports. The TPD forgot to communicate this to staff and was unaware staff was not turning his TV station to sports. Although R15 was dependent upon staff, and was unable to physically participate in activities without staff assistance, the facility had not completed a comprehensive assessment of R15's activity needs or care plan interventions to meet those needs. SUGGESTED METHOD OF CORRECTION: The director of activities or designee could develop, review, and/or revise policy and procedures related to activities. The director of activities or designee could assess residents for appropriate actives and care plan for residents based on a comprehensive assessment. The director of activities during the comprehensive assessment could assure dependent residents have stimulation daily. The director of activities or designee could then educate the staff on appropriate activities and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting,	21695		1/10/18

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and furnishings.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the kitchen was kept clean, sanitary and in good repair which had the potential to affect all 43 residents who received meals from the kitchen.

corrected

Findings include:

During observation of the kitchen on 11/28/17, at 9:15 a.m. with the Culinary Services Manager (CSM), a certified dietary manager, and the facility registered dietitian (RD)-A identified they fed 43 residents from the kitchen, the following items were noted:

A kitchen garbage can located near the hand washing sink had a a lid, that was covered in dirt, dust, debris and had a dried gray substances splashed on the lid. The external can also had dirt, dust, debris that was dried on the outside of the garbage can.

Near the hand washing sink was a four wheeled metal cart that had a base of an Oster Black and Decker blender along with other kitchen appliances on the cart that were covered with dust, crumbs and dried debris. The three shelves of the metal cart were also covered with crumb, dust and debris.

Through out the kitchen, the floor had an accumulation of various debris, dirt, crumbs and a sticky residue that stuck your shoes to the floor in front of the refrigerator. The area was approximately four feet in diameter. Under the

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	00866	A. BUILDING: ______ B. WING ______	12/01/2017

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refrigerator, carts, stoves, cook and prep area there was a heavy accumulation of visible crumbs, dirt and debris under all of these areas. There was a visible heavy build up of dirt and debris that was black in color located under the wheels and legs of the portable prep station, and refrigerator.

There was a stainless steel three shelf chart, near the prep station with dried food, and debris splashed on the sides and lateral supports of the cart, along with dirt, crumbs and debris on the shelves of the cart. CSM stated they used this for transporting food items in and out of the kitchen.

There was baseboard missing near the entryway of the dry storage area. The area was approximately 8 inches long by 4 inches long, and exposed the dry wall behind the baseboard.

There was a plastic three shelf cart in the dry storage area, that was full of dust, crumbs and debris on each of these shelves. CSM identified this was used for transporting food, and other items in the kitchen or to residents in the facility.

The dishwasher had a heavy white, cloudy residue on the outside. There was a heavier build up of this white substance on the four corner supports of the dishwasher.

The facility produce refrigerator had visible crumbs and food debris throughout the bottom of the refrigerator.

The chest freezer had a various crumbs on the bottom of the freezer, that had not been cleaned.

The refrigerator/freezer located in the serving room, had shelves with a build up of crumbs,

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debris and a sticky dried substance. The freezer had a heavy build of various creamy color sticky substances dried on the shelves. There were individual resident ice cream cups in the freezer. Outside on the refrigerator/freezer door there was brown, black colored debris on the bottom and edges of the refrigerator and freezer door, along with the same substance under the handles of the refrigerator and freezer.

During kitchen tour on 11/30/17, at 9:25 a.m. the following items were identified:

The window above the three compartment sink had visible dirt, debris and cob webs. The sink had a heavy white build up across the top of the sink, and around the faucets and faucet handles.

Inside the two storage units where pots, pans, lids and plastic containers were stored, the shelves had visible debris. The sliding door tracks had crumbs, debris and a brown substance in the tracking making it difficult to close the cupboard sliding doors. There were three plastic bins, that had a white build up on the sides, and under the handles had visible brown debris. Inside the two baking oven there was dried food, and crumbs on the bottom. There was a heavy build up of brown debris on the top and edges of the oven doors that could be scraped off with a fingernail.

The dish room had 12, 12x12 floor tiles in the dishwashing area and under the dishwasher. The tile corners were broken off, worn and had multiple large spider type cracks that extended the length and width of the 12x12 tiles. Other tiles had large cracks through the entire width of the tile. Under the dishwasher was a heavy build up of yellow, and tan color debris. Under the clean dish racks located next to the wall had an area

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approximately 6 inch by 2 foot long of a slimy tan colored substance. The dish racks had a heavy build up of a white visible substance. The wall between the dish room and kitchen area had 4, 4x4 inch white tiles missing. There was a linoleum piece in this area between the baseboard and wall not attached to the wall. Behind the linoleum was a hole in the wall. Across the wall in the dish area the tiles were splattered with a tan, brown substance approximately 8 feet long and 4 feet high. Lying against this wall were five clean dish racks.

Review of the daily cleaning schedules identified thirteen plus areas for daily cleaning of the floors, wipe off all carts, clean and wipe off all shelves, stoves, ovens, wipe down and clean coffee area. The bottom of the form identified, "Failure to complete daily cleaning may result in disciplinary action."

Review of the facility shift cleaning schedules from October 30 to November 26, 2017 identified 81 of 112 shifts cleaning were left blank.

During interview on 11/30/17 at 10:03 a.m. RD-A and CSM both stated they knew the kitchen needed some more work, and cleaning. They have been busy with staffing and the CSM has also been working in the kitchen as well. They just need more oversight, and we will make these changes.

Review of the Monarch Cleaning schedule policy, undated, identified each facility will be maintained in a clean, sanitary condition. The Department Director is responsible to provide and post the cleaning scheduled in their department. Each employee is responsible to know their assigned duty, and to carry it out during their work shift.

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Each employee is responsible to document in the specified area for their completed duty. Cleanliness will be maintained through regular cleaning.

SUGGESTED METHOD OF CORRECTION: The certified dietary manager or designee could develop, review, and/or revise policies and procedures pertaining to a clean and sanitary kitchen environment. The certified dietary manager or designee could provide education to all dietary staff on the need to adhere to cleaning policies and procedures for the kitchen. the certified dietary manager or designee could conduct audits to ensure cleaning is being completed.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.