Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 7015 0640 0003 5694 3603

December 6, 2016

Mr. Jason Nelson, Administrator
Lake Ridge Care Center of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

RE: Lake Ridge Care Center of Buffalo; Independent Informal Dispute Resolution (IIDR)
CMS Certification Number (CCN): 24 5513
Project Number: S5513025 Complaint Investigation Number: H5513019

Dear Mr. Nelson:

In a request dated November 25, 2016, Lake Ridge Care Center of Buffalo requested removal of deficiencies cited at F241 and F323, as a result of a recertification survey and substantiated complaint investigation completed on October 26, 2015 by the Licensing and Certification Program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated June 16th, 2016. This includes removal of the corresponding State licensing orders cited at *2 1665* and *2 1805*.

In addition, the Department has posted the revised results electronically since the facility is an active user of the electronic Plan of Correction (ePoC) system.

The revised CMS 2567, State form, CMS 2567b and State Form: Revisit Report are enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz

Holly Kranz, RN, Nursing Evaluator II

cc: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Pam Kerssen, Assistant Program Manager
Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245513 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0157	Correction	ID Prefix F0166	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.10(b)(11)	Completed	Reg. # 483.10(f)(2)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0167	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0242	Correction	ID Prefix F0244	Correction	ID Prefix F0250	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.15(c)(6)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0282	Correction	ID Prefix F0285	Correction	ID Prefix F0309	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.20(m), 483.20(e)	Completed	Reg. # 483.25	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0312	Correction	ID Prefix F0315	Correction	ID Prefix F0333	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.25(m)(2)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	BF/mm	12/06/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0353	Correction	ID Prefix F0356	Correction	ID Prefix F0371	Correction
Reg. # 483.30(a)	Completed	Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0412	Correction	ID Prefix F0428	Correction	ID Prefix F0441	Correction
Reg. # 483.55(b)	Completed	Reg. # 483.60(c)	Completed	Reg. # 483.65	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0490	Correction	ID Prefix F0520	Correction		
Reg. # 483.75	Completed	Reg. # 483.75(o)(1)	Completed		
LSC	12/29/2015	LSC	12/29/2015		

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FOLLOWUP TO SURVEY COMPLETED ON
10/26/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING _____ B. WING _____	10/26/2015

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F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on October 19, 2015, through October 26, 2015. In addition a complaint investigation was completed for H5513019, and was substantiated which resulted in a deficiency at F353. 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156		12/29/15

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

Electronically Signed | 11/27/2015

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F 156	Continued From page 1 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	F 156		

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F 156	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R98) were provided the required notice of Medicare non-coverage upon termination of the covered services. Findings include: A facility Admission/Leave/Discharge Tracking Report dated 4/15/15, to 5/25/15, identified R98	F 156	F156-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the	

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F 156	Continued From page 3 was admitted with a payment source of, "Medicare Part A," and remained in the facility for 32 days. R98's medical record was reviewed, however, no information was identified she had been provided the required notices of Medicare non-coverage prior to her Medicare services ending. During interview on 10/26/15, at 2:14 p.m. social worker (SW)-A stated there was no documented evidence R98 was provided a Notice of Medicare Provider Non-Coverage (CMS-10123). R98 was admitted for a therapy stay at the facility, and should have been given the denial notice two days before her covered services ended. During follow up interview on 10/26/15, at 2:55 p.m., SW-A stated the facility did not have a policy on ensuring the liability notices were given correctly, rather they, "Just follow Medicare guidelines."	F 156	administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to insure residents are provided the required notice of Medicare non-coverage upon termination of the covered services. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident is no longer on Medicare coverage. 2.Actions taken to identify other potential residents having similar occurrences: Reviewed all residents involved with Medicare back to the exit of the survey to ensure other residents that could potentially have been affected were identified. 3.Measures put in place to ensure deficient practice does not recur: Education was completed on 2 Nov 15 with Social Workers and MDS Coordinator to address the change in process for completing Medicare Denials using CMS Medicare guidelines as the resource. Social Worker will be notified at bi-weekly Medicare Meeting of upcoming denials and administer denials timely, followed by scanning into the medical record. 4.Effective implementation of actions will be monitored by:	

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F 156	Continued From page 4	F 156	MDS Coordinator will perform weekly audits to insure Medicare denials have been issued timely and scanned into the resident medical record. Findings will be reported to the Quality Assurance meetings for the next two quarters. 5.Those responsible to maintain compliance will be: The Social Worker will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 2015	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		12/29/15

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F 157	Continued From page 5 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily. Lake Ridge Care Center signed Physician Order Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. An Allina Health office visit note dated 4/20/15, indicated under "Your Plan" back on lantus 37 units at bedtime. R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in morning with a start date of 4/17/15 and Lantus at HS (at bed time), with a start date of 4/20/15. The	F 157	F157-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to update the medical doctor in a timely fashion. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 118's medical record for pain management was reviewed on 28 Oct 15. Medical providers contacted several times	

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F 157	Continued From page 6 Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15 to 4/26/15. The Buffalo Clinic Telephone order report dated 4/8/15, indicated at 8:58 a.m. received call from Lake Ridge care center, had blood sugar of 67 today, and told per orders to call if below 80. Per the Buffalo Clinic Telephone order report dated 4/27/15, Dr. Anderson indicated at 5:34 p.m., "Discussed with (staff) by phone. As of 4/20/15 visit, had written to return to Lantus 37 units at bedtime when it should have been once daily MORNING DOSE> Clarified with (staff) patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." Dr. Anderson then ordered Lantus 37 units once daily in the morning as prior to hospital stay. Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45 blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/25/15, indicated a blood sugar was only 51 while R45 was eating her breakfast meal. Review of the medical record did not indicate the physician was notified of the low blood sugar. Resident Progress Note dated 4/26/15, at 3:30 a.m. blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/27/15, at 8:33	F 157	since survey for review and adjustment of pain management. Resident 45's insulin/blood sugar orders were reviewed and the medical provider was updated multiple times since 30 Oct 15 to obtain orders for blood sugar parameter notification if symptomatic. 2.Actions taken to identify other potential residents having similar occurrences: All residents have the potential for pain. Residents with uncontrolled pain were reviewed to ensure the physician was aware of any changes and was updated with the changes related to pain. Resident's with diagnosis of diabetes have the potential for blood sugars outside of parameters. Resident's blood sugars were reviewed for past month to ensure the physician was aware of changes and was updated with the changes if needed. 3.Measures put in place to ensure deficient practice does not recur: Education on notification to medical provider with condition change, diabetic/ blood sugar management and pain management was completed by 13 Dec 15 for licensed nurses and TMAs. Morning IDT stand up meetings implemented on 30 Dec 15 to monitor for change in conditions and MD notification. 4.Effective implementation of actions will be monitored by: Will audit ten residents with changes in	

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F 157	Continued From page 7 a.m. indicated "Resident had low BS (blood sugar) this morning was sweating and shaky. she had a BS of 38. The physician was called at 8:44 a.m." Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated "Resident had been receiving Lantus 37 units BID (twice a day) since 4/20, miscommunication written upon return from appointment. Spoke with Dr. Anderson and the HS dose has been d/c'd (discontinued) and will continue the 37 units in AM." During interview 10/26/15, at 9:30 a.m. with the DON who stated she was not aware of the insulin discrepancy and stated she was unable to locate a medication error. The DON further stated the nurses should have called the physician when they noted the order for Lantus to be given at HS since she was not on that before and because of her low blood sugars. Although R45 had an order to notify the physician if blood sugars were below 80, the facility did not notify the physician of the three low blood sugars. The facility's Change in Resident's Condition Or Status policy dated 7/14, directed "POLICY: It is the policy of Elim Care, Inc. to promptly notify the resident, his or her Attending Physician, and representatives of changes in the resident's medical/mental condition and/or status."	F 157	condition related to blood sugars and pain with wound treatment to ensure medical provider was updated and will also audit ten MARs/TARs monthly for three months for pain effectiveness and blood sugars outside parameters to ensure medical provider was updated. Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior	F 166		12/29/15

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F 166	Continued From page 8 of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to attempt to resolve an individual grievance for 1 of 1 residents (R45) who had expressed concerns over lift placement and bruising. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated R45 was cognitively intact and required assistance of two staff for transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously... Had concerns about lift with sling placement and bruising [R45] felt she wasn't taken seriously." The action form indicated it was given to the DON. The form indicated the director of nursing (DON) response: "[R45] was not feeling well and gets paranoid/depressed with illness. this writer did visit with her and that she down played the concern." During interview on 10/22/15, at 2:10 p.m. the DON stated she was aware of R45's concern but did not feel it was a big deal. The DON stated it was about the lift but never investigated if there was bruising or how the staff were transferring the resident. The DON had not implemented any actions in effort to resolve R45's concern with the lift.	F 166	F166-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to resolve expressed grievances prompted by residents. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Weekly skin check completed on Resident 45 on 28 Oct 15 with no further bruises noted. Interviewed Resident 45 on 23 Nov 15 to ensure transfers were occurring according to resident preferences. Transfer observation with Resident 45 will be completed periodically as facility does mechanical lift transfer audits. 2.Actions taken to identify other potential	

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	245513	A. BUILDING _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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F 166	Continued From page 9 During interview on 10/23/15, at 12:23 p.m. with R45 stated the staff did not always listen to her when she made a concern. R45 stated a few months ago when she was being transferred from her ceiling lift, the strap was not connected correctly and it slid down on her right arm, causing a skin tear and bruising. R45 was "irritated" because she "made a grievance in resident council", but didn't "think anything was done about it." A facility Grievances and Complaints policy dated 1/12/12, indicated, "It is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." Further, the policy indicated, "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager."	F 166	residents having similar occurrences: The facility Vulnerable Adult log and Resident Council minutes from October were reviewed by Administrator. Interviewable residents will be interviewed by for potential VA concerns and non-interviewable resident's weekly skin checks will be viewed to determine injuries of unknown origin and follow-up needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur: Grievance and Complaints policy and form was reviewed and revised by 30 Oct 15. Staff education on handling resident grievances and concerns and nursing staff education on transfer techniques with mechanical lift will be completed on 13 Dec 15. Administrator will review Resident Council minutes after Resident Council meetings beginning in November 2015. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Facility will complete five NAR Care Observations weekly for three months. Audits will be completed on grievance log and Resident Council minutes monthly for three months. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that	

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F 166	Continued From page 10	F 166	time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure the most recent State survey results were readily available for resident and family review. This had the potential to affect all 48 residents, visitors and staff who wished to review the information. Findings include:	F 167	F167-C Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission	12/29/15

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F 167	Continued From page 11 During the initial tour of the facility on 10/19/15, at 6:42 p.m. a clear plastic holder was attached to the wall by the entry way which contained a white three ring binder. The binder contained State survey results dated 10/24/13 (two years prior). When interviewed on 10/26/15, at 5:30 p.m. the administrator stated he or the licensed social worker (LSW)-A were responsible to update the results, and the 2014 survey should have been displayed.	F 167	against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to post survey results so that they are available for residents and families to review. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The most recent survey results were posted on 26 Oct 15. 2.Actions taken to identify other potential residents having similar occurrences: All residents had potential to be affected by alleged deficient practice. 3.Measures put in place to ensure deficient practice does not recur: Staff education addressing CMS requirements for posting of most recent survey results was completed by 13 Dec 15. Survey book will be updated with new survey result by Administrator as they are available. 4.Effective implementation of actions will be monitored by: Facility receptionist will verify correct survey results are posted on a weekly basis and will complete the audit tool for three months. The results collected will be presented to the next Quality	

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F 167	Continued From page 12	F 167	Assessment & Assurance Committee quarterly meeting. At that time, the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		12/29/15

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F 225	Continued From page 13 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator, state agency and thoroughly investigated for 3 of 5 residents (R45, R104 and R131) whose allegations were reviewed. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated she was cognitively intact and required assist of two staff with transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously" R45 had "concerns about lift with sling placement and bruising," and, "felt she wasn't taken seriously." The form identified it was given to the DON who responded, "Res	F 225	F225-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to report allegations of abuse, neglect and injuries of unknown origin immediately to the administrator and state agency. To assure continued compliance, the	

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F 225	Continued From page 14 [resident] was not feeling well and gets paranoid/depressed with illness ... did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern. The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any bruising on R45. During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was no indication the adminstrator and the state agency were immediately notifed, nor had an investigation been completed of the allegation. R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door	F 225	following plan has been put into place; 1. Regarding cited residents: Incident for Resident 45 was submitted on 27 Nov 15 to OHFC. Investigation and follow-up will be completed per regulatory compliance. Resident 131 and Resident 104 had VAA reports filed before survey. 2.Actions taken to identify other potential residents having similar occurrences: The facility Vulnerable Adult log and Resident Council minutes from October were reviewed by Administrator. Interviewable residents will be interviewed by for potential VA concerns and non-interviewable resident's weekly skin checks will be viewed to determine injuries of unknown origin and follow-up needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur: Facility Vulnerable Adult policy was reviewed and revised and education on VAA abuse prohibition and reporting requirements was completed with staff and the facility guidelines for VAA reporting online was updated and education was completed with licensed staff by 13 Dec 15. A revised grievance and concern log was implemented on 28 Dec 15 to include "desired outcome". Facility has implemented daily IDT stand up meetings starting 30 Oct 15 to monitor for potential vulnerable adult concerns. 4.Effective implementation of actions will be monitored by:	

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F 225	Continued From page 15 and overheard a mans loud voice that was not resident yelling and swearing. Writer was unable to hear what was all being said but did her the word "Fuck", and "your and Asshole" in an angry tone of voice. Writer immediately went into room with nurse and saw resident's family member (FM)-A was yelling at resident. Resident was asked if he wanted FM-A to leave. Resident said yes. FM-A was asked to leave several times by writer before he complied with leaving. FM-A at the time was holding up his phone that had a light and was pointed towards resident. Resident was asked if his FM-A was video taping him. Resident stated yes. Writer asked residnet if FM-A had his permission to do this and resident stated "no". Resident also stated that (FM-A) has, in the past, been physically abusive to him and has also threatened to kill him in the past while at residents home. Resident stated that FM-A had actually pushed him into a bonfire at residents home to try to kill him, and he still had the scars to show for it. Resident express that he didn't know if he wanted FM-A back here at the facility since he has been the only one that has been helping him. Resident also let writer know that FM-A now had keys to his home, truck and was refusing to give those back. FM-A told the resident, "you will have to break into your house if you think you are going back there". Resident also stated FM-A has his laptop and refusing to give that back. The investigation was submitted to the state agency on 7/01/15. During interview 10/26/15, at 6:13 p.m. with the DON who stated the incident should have been immediately reported and she did not know why it had been reported late. Although the incident occurred on 6/26/15, the	F 225	Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Facility will complete five NAR Care Observations weekly for three months. Facility will complete five Abuse Education Audits of staff; audits will also be completed on grievance log and Resident Council minutes monthly for three months. Facility will monitor VAA reports monthly for three months for timeliness of reporting to the Administrator and state agency. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	

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F 225	Continued From page 16	F 225		

facility did not report the incident to the administrator and state agency until two days after the incident, on 6/29/2015.

R131's quarterly MDS dated 2/25/15, indicated she was moderately cognitively intact and needed extensive assist of two with transfers.

An Investigative Report dated 4/5/15, indicated that on 4/3/15 R131 had a, "exp. large discolored area to the lateral left breast" which measured 10 cm (centimeter) by 8 cm in size. R131 was reassessed for her ability to continue to be transferred in this type of device, and R131 was determined to require a hoyer lift for transfers. The administrator and the state agency was informed of the incident on 4/5/15 two days later and the investigation was submitted to the state agency on 4/13/15, 10 days after the incident occurred and identified the injury was from a mechanical lift.

During interview 10/22/15, at 2:17 p.m. DON stated the investigation was sent late and didn't know why it was sent late "maybe it was a computer glich". Further, the DON stated because of the size and the location, the incident needed to be reported.

Although the injury was noted on 4/3/15, the facility failed to inform the administrator and and the state agency two days later and the investigation was not reported until 10 days later.

The facilities Vulnerable Adult Abuse Prohibition Policy and Procedure revised November 2011, indicated "Each employee is responsible to report suspected/alleged violations of resident

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F 225	Continued From page 17 abuse/neglect immediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The administrator will be notified immediately by on of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy for the timely reporting and investigation of allegations of abuse, neglect, or injuries of unknown origin for 3 of 5 residents (R45, R104, and R131) whose allegations were reviewed. Findings include: A facility Vulnerable Adult Abuse Prohibition Policy and Procedure revised November 2011, indicated, "Each employee is responsible to	F 226	F226-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the	12/29/15

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F 226	Continued From page 18 report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The administrator will be notified immediately by on of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated she was cognitively intact and required assist of two staff with transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously" R45 had "concerns about lift with sling placement and bruising," and, "felt she wasn't taken seriously." The form identified it was given to the DON who responded, "Res [resident] was not feeling well and gets paranoid/depressed with illness ... did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern. The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any	F 226	drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Incident for Resident 45 was submitted on 27 Nov 15 to OHFC. Investigation and follow-up will be completed per regulatory compliance. Resident 131 and Resident 104 had VAA reports filed before survey. 2.Actions taken to identify other potential residents having similar occurrences: The facility Vulnerable Adult log and Resident Council minutes from October were reviewed by Administrator. Interviewable residents will be interviewed by for potential VA concerns and non-interviewable resident's weekly skin checks will be viewed to determine injuries of unknown origin and follow-up needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur: Facility Vulnerable Adult policy was reviewed and revised and education on VAA abuse prohibition and reporting requirements was completed with staff and the facility guidelines for VAA	

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F 226	Continued From page 19 bruising on R45. During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was not investigation done and adminstrator and the state agency were not notified immediately. R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door and overheard a mans loud voice that was not resident yelling and swearing. Writer was unable to hear what was all being said but did her the word "Fuck", and "your and Asshole" in an angry tone of voice. Writer immediately went into room with nurse and saw resident's family member (FM)-A was yelling at resident. Resident was asked if he wanted FM-A to leave. Resident said yes. FM-A was asked to leave several times by writer before he complied with leaving. FM-A at the time was holding up his phone that had a light and was pointed towards resident. Resident was	F 226	reporting online was updated and education was completed with licensed staff by 13 Dec 15. A revised grievance and concern log was implemented on 28 Dec 15 to include “desired outcome”. Facility has implemented daily IDT stand up meetings starting 30 Oct 15 to monitor for potential vulnerable adult concerns. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Facility will complete five NAR Care Observations weekly for three months. Facility will complete five Abuse Questionnaire Audits of staff; audits will be completed on grievance log and Resident Council minutes monthly for three months. Facility will monitor VAA reports monthly for three months for timeliness of reporting to the Administrator and state agency. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	

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F 226	Continued From page 20	F 226		

asked if his FM-A was video taping him. Resident stated yes. Writer asked residnet if FM-A had his permission to do this and resident stated "no". Resident also stated that (FM-A) has, in the past, been physically abusive to him and has also threatened to kill him in the past while at residents home. Resident stated that FM-A had actually pushed him into a bonfire at residents home to try to kill him, and he still had the scars to show for it. Resident express that he didn't know if he wanted FM-A back here at the facility since he has been the only one that has been helping him. Resident also let writer know that FM-A now had keys to his home, truck and was refusing to give those back. FM-A told the resident, "you will have to break into your house if you think you are going back there". Resident also stated FM-A has his laptop and refusing to give that back. The investigation was submitted to the state agency on 7/01/15.

During interview 10/26/15, at 6:13 p.m. with the DON who stated the incident should have been immediately reported and she did not know why it had been reported late.

Although the incident occurred on 6/26/15, the facility did not report the incident to the administrator and state agency until two days after the incident, on 6/29/2015.

R131's quarterly MDS dated 2/25/15, indicated she was moderately cognitively intact and needed extensive assist of two with transfers.

An Investigative Report dated 4/5/15, indicated that on 4/3/15 R131 had a, "exp. large discolored area to the lateral left breast" which measured 10

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F 226	Continued From page 21 cm (centimeter) by 8 cm in size. R131 was reassessed for her ability to continue to be transferred in this type of device, and R131 was determined to require a hoyer lift for transfers. The administrator and the state agency was informed of the incident on 4/5/15 two days later and investigation was submitted to the state agency on 4/13/15, 10 days after the incident occurred and identified the injury was from a mechanical lift. During interview 10/22/15, at 2:17 p.m. DON stated the investigation was sent late and didn't know why it was sent late "maybe it was a computer glich". Further, the DON stated because of the size and area it was on, she felt it needed to be reported. Although the injury was noted on 4/3/15, the facility failed to inform the administrator and and the state agency two days later and the investigation was not reported until 10 days later. .	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 242	F242-D	12/29/15

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F 242	Continued From page 22 facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for choices. Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, indicated he was cognitively intact, needed assist of two staff with bathing, and it was "very important" to be able to chose the method in which he was bathed. R73's care plan dated 9/25/15, identified he had been admitted in September 2015, but did not identify any preferences or assistance R73 required with bathing. R73's undated Nursing Assistant Care Sheet indicated he received a tub bath on Thursday by an outside agency. During interview 10/21/15, at 10:02 a.m. R73 stated hospice is to be giving me two baths a week and the facility is supposed to also be giving me two baths a week. R73 then stated, "I have only received two baths from the facility since I have been here." The facilities Mill Creek Bridge Weekly Bath and Vital List dated 9/21/15 to 10/22/15, identified the following: > The week of 9/21/15 to 9/27/15, R73 was not identified on the bath list. > The week of 9/28/15 to 10/4/15, R73 continued to not be identified on the bath list. > The week of 10/5/15 to 10/11/15, R73 was scheduled to receive four baths, but only had one bath documented as being completed. > The week of 10/12/15 to 10/18/15, R73 was again scheduled to receive four baths, but only had one bath documented as being completed. > The week of 10/19/15 to 10/22/15, R73 was scheduled to recieve three baths, but only had two baths documented as being completed. The bath listing identified R7 received two baths from the facility and two baths from the outside agency, a total of 4 out of the 11 baths he should	F 242	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to honor resident's bathing preferences. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 73 was interviewed for bathing preference on 27 Nov 15 to verify resident preference expressed on 21 Oct 15. Care plan and NAR guides updated to reflect resident preference of baths per week; Hospice will be assisting with resident bathing preferences giving two baths per week and facility providing two. 2.Actions taken to identify other potential residents having similar occurrences: Interviewable Residents were questioned using a modified CMS Resident QIS Interview tool to include bathing preferences and care plans to be updated if needed. 3.Measures put in place to ensure	

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F 242	Continued From page 23 have received. During interview 10/23/15, at 9:15 a.m. nursing assistant (NA)-F stated the staff do the best they can, but added, "We do not have a bath aide and we just can't get all of them done so some of the baths have been missed. That's all I can say." During interview 10/23/15, at 9:21 a.m. registered nurse (RN)-A stated R73 should have received his bath according to his choice adding if it was not documented on the listing, it was not completed. A facility policy on choices was requested, but none was provided.	F 242	deficient practice does not recur: Facility revised process for interviewing residents about bathing/showering preferences upon admit and with comprehensive RAI reviews. Facility process and procedure for bathing was reviewed and revised. Care staff and Activities educated on change of practice with bathing preferences and honoring Resident choices by 13 Dec 15. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents	F 244		12/29/15

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F 244	Continued From page 24 and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely follow-up to the resident council groups grievance as concerned with inadequate staffing in the facility. This affected 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. Findings include: During the recertification survey, the resident council minutes were reviewed and identified the following: The resident council minutes dated 7/28/15, indicated under nursing R27, R19, R45, "All feel we do not have enough nursing help due to how long it takes for their call lights to be answered. Writer [activity director (AD)] explained the difference between cutting hours due to census vs. [versus] being short staffed." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R19, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/12/15, from the director of nursing (DON) provided a response which identified, "There are times of the day and night when many residents are requesting assistance at the same time. We are getting to each one of them as quickly as possible we are adequately staffed. Some employees are new and work a little slower while they are learning." The resident council minutes dated 8/13/15, identified, "Updates on last meeting concerns"	F 244	F244-E Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to provide timely follow-up to resident council groups' grievances and concerns regarding inadequate staffing in the facility. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The Administrator reviewed most recent Resident Council monthly minutes and will report back to Resident Council at the next meeting in December to follow up with action steps the facility is utilizing to address related staffing concerns. R27, R19, R45, R35 and R21 will be invited to	

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F 244	Continued From page 25 were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention too! Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes dated 9/29/15, identified, "Council members are concerned about staffing. Writer [AD] explained staffing. [R21] had concern about waiting to go to his meal for too long. Writer explained about the requirement for a NAR's [nursing assistant, registered] to be able to sit with residents who need assist to eat and that this way likely the reason he had to wait." There was no evidence the repeated concerns regarding inadequate staffing at the facility were addressed by the management team. During interview on 10/23/15, at 12:23 p.m. R45 stated she did not feel the concerns voiced during the council meetings were addressed, adding, "They are so short staffed here at the facility sometimes I have to wait 45 minutes for the staff to help me you see I am immobile and need help to get on the bed pan to have a BM [bowel movement] and when they are late, I can't wait so I have an accident in the bed and that is not pleasant for me."	F 244	the by December Resident Council where follow-up to resident concerns will be addressed. 2.Actions taken to identify other potential residents having similar occurrences: The most recent Resident Council minutes were reviewed by Administrator to identify additional resident complaints and ensured follow up was completed. 3.Measures put in place to ensure deficient practice does not recur: Facility Administrator reviewed and revised Grievance and Complaints policies, and education was provided to Department Heads on 23 Nov 15 on grievances. An update on the annual survey will be presented at the Resident Council meeting in December. 4.Effective implementation of actions will be monitored by: Administrator will review Resident Council minutes to ensure follow up has been completed following every Resident Council meeting for six months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting by the Activity Director, and at that time, the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	

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F 244	Continued From page 26 During interview on 10/23/15, at 9:30 a.m. the AD who stated she is in charge of the resident council meetings. AD stated, "The residents do complain about the staffing here and it's a problem everywhere. I let the DON know about their concerns. I always tell them we are trying and with so many residents sometimes you just have to wait." Although R27, R19, R45, R35 and R21 had complaints of staffing on 7/28/15, their concerns continued at the 8/13/15 and 9/29/15 resident council meetings with no objective, measurable plan being identified to resolve there concerns of staffing. The facility Grievances and Complaints policy dated 1/12/12, indicated "it is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." The policy further indicated "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager."	F 244	Completion date for certification purposes only is: 29 Dec 15	
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 250		12/29/15

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F 250	Continued From page 27 by: Based on observation, interview, and document review, the facility failed to ensure medically related social services needs were identified and provided for 2 of 4 residents (R29 and R28) reviewed for social services. This resulted in actual, psychosocial harm for R28, who expressed fear, inability to sleep, and demonstrated signs of distress regarding concerns with her roommate (R29). Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/25/15, indicated the resident had severe cognitive impairment and had dementia with depression. R28's quarterly MDS dated 9/1/15, indicated the resident had severe cognitive impairment, and had dementia with depression. The MDS indicated R28 was depressed, had trouble sleeping, had little or no energy, felt bad about herself, and had trouble concentrating. R28's Care Area Assessment (CAA) dated 6/12/15, indicated the resident received Zoloft, an antidepressant, for diagnosis of depression. R28's care plan dated 9/11/15, indicated she was depressed and was to receive one to one visits to encourage expression of feelings and to, "Explore possible reasons for the resident's distress (e.g., environmental/psychosocial stressors, treatable medical conditions, etc); Implement a mood management plan to compliment drug therapy : sertraline (Zoloft)." The care plan indicated R28 had the potential for abuse from others related to cognitive loss, and the approach was for staff to	F 250	F250-G Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 28 and family were interviewed by Social Service and was moved to a private room on 12 Nov 15. Resident 28 was seen by Associated Psychology and follow up recommendations were added to the care plan. Resident 29 discharged to another facility on 23 Nov 15 to accommodate memory care needs. Family care conference held with Resident 56, spouse, social services,	

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F 250	Continued From page 28 discuss behavioral issues with the team members as needed, and evaluate the need for psychological referral and evaluation. R28's progress notes reviewed from 7/09/15, to 10/25/15, indicated the following incidents related to R29, who is R28's roomate: On 7/9/15, "Res. [resident] has been crying today. Res. is stating how when she was little her mom used to make her watch the baby and she didn't like it. Res. has also been say that her roommate asks so many questions and needs things and she is getting tired." On 7/15/15, a note documented by activities indicated "Resident is having a hard time with her rooming situation. She says she is not getting much sleep because roommate is up a lot at night talking, delusional as to where she is and accusing resident of things. Resident is crying a lot and is in hopes of changing rooms. Writer consoled resident and said she would see what she could do about the situation." On 8/24/15, resident and roommate had a dispute. R28 stated her roommate yelled at her and she became upset, was crying, and stated she was done dealing with her roommate and wanted a new room. On 8/25/15, a progress note from social services indicated, "Spoke with res regarding incident with roommate last night, res did remember arguing with her roommate. She didn't say she wanted a different room today, but just said that she didn't want to talk to her roommate about just anything, only the weather. Writer validated her feelings letting resident know she doesn't have to talk to	F 250	certified dietary manager and corporate dietitians on 18 Nov 15. Diabetic diet reviewed with resident including appropriate snacks available. Resident and spouse were both able to voice back on education they received on carb counting, portions sizes, reading food labels and risks of not following a diabetic diet. Resident was able to site complications of uncontrolled diabetes that included problems with wounds, eyes, heart, kidneys and vessels. We reviewed healthy snack options and reminded them that facility provides them. Follow up appointment scheduled with diabetic educator in early December. Level II PASRR completed on 11/5/15 and stated that “This person’s medical and health needs are such that he/she requires NF services. This person will be admitted to the NF on 9/10/15” also states “This person’s medical and health care needs are so severe that, in the judgement of the QDDP, the person cannot be expected to benefit from active treatment.” Social Services will continue to work with County Social Worker on clarifying resident’s needs. 2.Actions taken to identify other potential residents having similar occurrences: Social Service reviewed care conferences from past quarter to identify possible additional residents with room-mate concerns with no further action needed. A diagnosis list was run from the facility software to identify other residents with related diagnosis of Developmental Disability or related condition to determine if any other residents met criteria for a	

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F 250	Continued From page 29 roommate about anything she didn't want to." On 9/1/15, "Resident refusing to go into bed as roommate blocking roommate from entering. Resident when in room, 'peeks' into roommates side of room to make sure she is okay." On 9/5/15, resident talked with writer and stated, "I'm loosing my mind, my roommate is rubbing off on me; up at 1 am. Talks of wanting a different room, did leave a message for SW [social worker], 1 on 1 with resident, and was effective at this time." On 9/10/15, resident complaints of not sleeping well last night stating the lady in her room kept her up asking who she is and where she is. On 9/10/15, progress note from social services indicated, "Writer was walking down the hall and res stopped writer and was upset because she stated 'I just saw on TV that I am being taken to court! I have nothing, this is not fair they stole all my money!' When writer asked who stole her money she was not able to say. Res roommate was then coming out of the room and res said 'oh that little bitch! She was screwing with him all night!' Writer let res know that was not nice to call some one names. Writer asked who him was and roommate got closer res said 'oh look here she is she just wants to screw' and she shook her fist at roommate. Writer directed ladies in opposite direction but it took some time for residents to go there separate ways. Res kept stating that 'this is my room' and 'she goes in there all the time and screws him, she is such a little bitch, I cant even eat- I don't even want to look at her." On 9/12/15, resident found in roommates bed	F 250	level II screening and need for active treatment. 3.Measures put in place to ensure deficient practice does not recur: The facility implemented a daily IDT morning meeting with Social Worker in attendance to discuss social service and/or room-mate concerns. Staff educated on overview of PASRR, resident to resident altercation and interventions and resident non-compliance by 13 Dec 15. MDSs will be completed upon admission, quarterly and with significant change to include non-compliance and risk versus benefits. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly times one quarter. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Social Services is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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and she stated she does this to me all the time.

On 9/23/15, resident stated she was up all night with the lady in her room yelling all night. Resident stated she was, "Going crazy." One to one was given.

On 9/23/15, "Writer unplugged cord from computer res. stating 'I wish I had one of those' res was asked what? 'That cord for around my neck- I don't sleep cause of that lady in my room.' Res. stated 'I really wont do that but I never get any sleep with her in there.' 1 on 1 was given with relief. SS updated."

On 10/6/15, social service note indicated residents daughter called, "To talk to writer about concerns that resident called her about a man who was after her and her roommate, who was sleeping with all sorts of men and how resident just wanted to commit suicide. Assured Dtr [daughter] that no men were in the building and that res has talked about seeing the men before and they turn out to be not here and roommate does not have men in her bed at night to which [daughter] stated she figured and was not worried about it. She [daughter] was most worried about the suicide comment. [Daughter] is requesting a call from the MD [medical doctor] when he is here on Thursday and Writer let [daughter] know that she would talk to MD as well about res behaviors. Writer then spoke to res about suicidal behaviors and res has no plans to harm herself and is safe at facility. No further action needs to take place today."

On 10/07/15, "Res in confrontation with another Res in hallway this evening. Res was talking about going to 'See my lawyer this week to see

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what the weather is going to be.' She was also talking about how another res 'needs her ass kicked.' Res eventually calmed down and went into her room. Will continue to monitor."

A Lake Ridge Care Center Fax Update/Order form dated 10/8/15, indicated the MD attempted to call R28's daughter but had the wrong phone number and he would call the social worker tomorrow.

On 10/20/15, "Writer informed by NAR (nursing assistant registered) that Res claims roommate said she was going to cut her throat. Res called daughter to inform daughter of situation. Writer asked aides what happened. Aides said roommate didn't want to go in room because Res said she didn't want her there. Then Res made the claim that roommate said she'd cut her throat. Aides said roommate wasn't even around Res to make such a comment. Res and roommate separated at this time. Res on her way back to bed."

On 10/22/15, social service note indicated "Met with resident and discussed comments she made on 10/20/15. Res stated that she did not feel her roommate was going to slit her throat, res stated she felt safe and was not afraid of her roommate. She stated her roommate just wants the whole room that's all and she just gets that way sometimes. Asked res twice if she felt safe with her roommate during the conversation and both times res waved her hands at writer and said oh yes its fine."

On 10/23/15, social service note indicated resident came to writer upset with roommate because of all of her visitors and that she needed

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to get out of her room because her roommate gets mad at her and shuts the door on her. Because she was so upset writer asked if she felt like hurting herself and res stated, "No, I don't think so."

On 10/23/15, "Resident was up at the front door saying 'I am getting out of here.' Writer told resident, Oh it's raining out. You don't want to go out there. Resident replied, I don't care about the rain. I'm not staying here another night; live with these awful people here, I'm leaving. Resident was resistant at first but then writer got resident to go to the Vineyard. Writer reported this info to social services and nursing. At this time nursing put a Wanderguard on resident."

An Associated Clinic of Psychology visit note dated 8/17/15, indicated R28 had depression, and did not have suicidal ideation. The recommendations were to use validation techniques when she appeared to have concerns, or when she voiced concerns.

A Geriatric Services Of Minnesota physician visit dated 9/10/15, indicated, "The patient [R28] did get a bit weepy today while complaining about conflicts with her roommate. I spoke with various staff and apparently the patient has had problems with at least a couple of other roommates and I think she maybe a candidate for a private room." The plan indicated to facility staff, "I will be happy to support a waiver request for a private room."

There was no indication the physician recommendation regarding R28 receiving a private room was followed up on by the facility.

During interview on 10/26/15, at 1:53 p.m.

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F 250	Continued From page 33 nursing assistant (NA)-T stated R28 and R29 started to have troubles being roommates a few months ago, because R29 gets, "Crazy" in the late afternoon and night time. R29 becomes more confused, and is up hollering during the night. NA-T stated they have come to work in the early morning and R28 would be awake and out of bed crying stating she is fearful of her roommate because R29 was, "Making her uncomfortable." R28 had expressed she, "Doesn't like being in that room," and continued to be "unsettled" about having to remain in the room with R29. R28 had ongoing episodes several times a week of not sleeping well at night because of R29, and NA-T stated these concerns were reported to social worker (SW)-A, but SW-A stated she had spoken to R28's family and they didn't want the resident to change rooms, but rather just wanted the facility to add some pictures and music to try to enhance the physical space of the room for R28. NA-T stated one of R28's daughters had recently visited from out of town, and she had expressed desire for R28 to change rooms because she could, "See how it was," between R28 and R29; however, NA-T stated, "Nothing ever got done," about R28 and R29 rooming together. During interview 10/26/15, at 4:08 p.m. NA-A stated R28 and R29, "Argue all the time, and [R29] is very forgetful; she cant remember five minutes to the next." She forgets what side of the room she is on and they both dig into each others things and it upsets both of them. "[R28] gets upset and will go on a rant that she has no one in her family; she has said she is better off dead but never told me she had a plan. She is not on any suicide checks. We are told there is not enough charting to separate them and the nurses do the	F 250		

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charting. It would be nice if they could be separated."

During interview 10/26/15, at 4:13 p.m. licensed practical nurse (LPN)-A stated, "They [R28 and R29] fight a lot. I have asked for a room change and left messages with the social worker. I'm almost ready to give up; we keep charting and nothing gets done with it and the staff are very frustrated, they don't ask us about room changes and about what would work best, and who would be compatible with who. I suggested for her [R28] to move to room 126 when that was open because I felt her and the other roommate would be a good fit and they never moved her. [R28] tells me she wants to move.... [R28] says things that she wants to kill herself." LPN-A then stated, "I don't think things are charted as often as they occur." LPN-A stated R28 and R29 just, "Got into it with each other in the hall."

During interview 10/26/15, at 4:23 p.m. R28 stated, "I have never been treated like this ever in my life." R28 started to cry, and LPN-A (who was present at the time of interview) gave her a Kleenex. R28 stated, "I have asked for a different room, I want a different room, and I have told the gals that work here that!" R28 continued to cry wiping her tears with her Kleenex. R28 then began rubbing her head and stated, "Oh my god I am so tired of this, I have it in the back of my mind to end my life. I am 86 years old, why do I have to put up with this?" R28 stated her roommate (R29), "Is nastier than nasty." At 4:33 p.m., R28 was still crying.

During interview on 10/26/15, at 4:36 p.m. social worker (SW)-A stated everyone at the facility was aware R28 and R29 did not get along. SW-A

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F 250	Continued From page 35 stated she and the director of nursing (DON) had discussed moving the residents to separate rooms, but felt it would not be a benefit to move either one of them. SW-A stated R28 hallucinates and had made comments about a man being in the room when there hasn't been a man around. SW-A stated she was not aware if R29 was keeping R28 up at night, and stated she had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty rooms all have roommates, and the facility felt they would rather wait for a private room to open before moving R28. SW-A stated she had not filled out a waiver for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated R28 had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 8/17/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here." During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken to her about moving R28 to a different or private room.	F 250		

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F 250	Continued From page 36 During interview 10/26/15, at 6:03 p.m. DON stated a lot of the staff know there, "Is a clash between [R28] and [R29]." The DON stated she was not aware where the social worker was at with the situation between the resident, and the SW made the determination regarding resident room assignments, however, the DON stated, "I am not sure why they haven't moved one of them." DON stated she heard about suicidal comments from R28, but was not aware R28 made a comment about wanting a cord for around her neck, and stated, "If she [R28] said that, she had a plan." A facility policy addressing the responsibilities of social services was requested, but was not provided.	F 250		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and	F 282	F282-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission	12/29/15

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F 282	Continued From page 37 required extensive assistance with personal hygiene, including brushing his teeth. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room, and showed he had several missing teeth on his upper palate when asked about his oral health. R5's care plan dated 7/14/15, identified R5 had an, "Alteration in ADLs [activities of daily living] of dressing, grooming and bathing...". Further, the care plan directed staff to assist R5 with, "Oral care am [morning] and pm [evening]..." During interview on 10/23/15, at 12:55 p.m. NA-F stated the care plan is used to know "what we're [staff] supposed to do" for the residents care. NA-F helped R5 get ready for the day, but did not offer or assist him to complete oral cares. Further, NA-F stated she should make sure R5 is having his teeth brushed and cleaned so R5 doesn't develop oral disease, or loose additional teeth. When interviewed on 10/23/15, at 1:04 p.m. RN-A stated R5 needs to be set up with assistance to complete oral cares, and NA-F should have offered his oral cares, "That's what should be happening." A facility policy regarding care plan implementation was requested, but was not provided.	F 282	against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to provide oral cares as directed by the plan of care. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 5 was interviewed for preferences related to oral care on 30 Oct 15 and care plan/NAR Care guide updated. Oral care audits on Resident 5 will be completed periodically as facility does NAR Care Audits to ensure oral cares delivered according to care plan. 2.Actions taken to identify other potential residents having similar occurrences: Residents identified as having potential to be affected by area cited are residents who require assist with oral cares. 3.Measures put in place to ensure deficient practice does not recur: Education provided to care related staff by 13 Dec 15 providing oral care and following resident care plans. Resident Care plans and NAR care guides will be updated to reflect resident oral care needs. MDSs will be completed upon admission, quarterly and with significant change to include oral care needs.	

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F 282	Continued From page 38	F 282	4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an	F 285		12/29/15

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F 285	Continued From page 39 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 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 mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation 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 mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) level 2 evaluation was completed for 1 of 1 resident (R56) with a diagnosis of moderate intellectual	F 285	F285-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions	

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F 285	Continued From page 40 disability. Findings include: R56's undated Resident Admission Record identified a diagnosis of other specified mental disorder due to known physiological condition. R56's Initial Pre-Admission Screening (PAS) Results based on information submitted on 9/9/15, by the Buffalo Hospital social worker (SW)-C, identified she had a diagnosis of mild intellectual disabilities. The screening noted, "Based on the information provided for this nursing home stay, it appears this person meets the criteria for DD [developmental disability] and needs to be referred to the lead agency for further evaluation. Please note final determination of the need for referral for further evaluation will be made by Senior LinkAge Line ®." A Fax Transmittal Sheet dated 9/10/15, sent to the facility social worker (SW)-A from Central MN Council on Aging/ Senior LinkAge Line ®, noted R56's PAS was forwarded to Wright County for processing, as per the process for residents identified on a home and community based services (HCBS)- waiver. A PASRR level 1 screening dated 9/10/15, completed by R56's Wright County case manager declared R56 did not have a developmental disability or related condition (DD/RC), had never been considered to have DD/RC, had no presenting evidence that might have indicated the presence of DD/RC, and had not been referred for nursing or boarding care facility placement by an agency that served persons with DD/RCs. Since none of these conditions were identified, no	F 285	or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure PASRR evaluations are completed with a diagnosis of moderate intellectual disability. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The facility received a Level II Preadmission Screening from Irina Steuven, Wright County Social worker on 5 Nov 15. 2.Actions taken to identify other potential residents having similar occurrences: A diagnosis list was run from the facility software to identify other residents with related dx of Mental Retardation or Mental Illness to determine if any other residents met criteria for a level II screening. 3.Measures put in place to ensure deficient practice does not recur: Social Worker, or their designee, has been educated on PASRR and will be reviewing Senior LinkAge Line PAS forms for notation that resident may have DD or Mental Illness. Social Worker or designee	

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F 285	Continued From page 41 referral was made for completion of a PASRR level 2 evaluation. An additional PASRR level 1 screening dated 9/11/15, was maintained as part of R56's medical record. This screening was completed by registered nurse (RN)-F, with no associated agency identified on the forms. This screening declared R56 did have a DD/RC and presenting evidence was present that may have indicated the presence of DD/RC. Though conditions were identified, no referral was made for completion of a PASRR level 2 evaluation. During interview on 10/26/15, at 9:06 a.m. SW-A stated she had noted R56 as potentially requiring a PASRR level 2 when she did her pre-admission screening before she was accepted as a new admission. SW-A stated Senior LinkAge Line ® typically contacted the facility when a level 2 evaluation was required, then a county worker typically came out to the facility to complete the level 2 screening. SW-A reported she did not know if it was the facility's responsibility to follow-up if the county did not come out. When asked whether R56 had a DD/RC diagnosis, SW-A stated she did not see any diagnoses in her medical record to support this. She stated the hospital told her R56's county case manager was very involved and there was a discussion of potential placement at a group home. SW-A stated, "If you talk with her and are around her it seems like there would be a DD diagnosis." During a telephone interview on 10/26/15, at 9:41 a.m. SW-D stated she had worked with R56 for over a year and a half. SW-D reported R56 "definitely" required more one-on-one attention and the county was currently considering the	F 285	will compare Senior LinkAge Line PAS, Level I and resident diagnosis for pertinent diagnosis that would indicate the need for a Level II. Social Worker is responsible to attach Preadmission Screening to resident electronic medical record. 4.Effective implementation of actions will be monitored by: The facility will audit five residents' charts per month for three months, comparing Senior LinkAge Line PAS, PASRR and diagnosis list to determine if Pre-admission screening Level II was completed as required. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Social Worker is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 285	Continued From page 42 pursuance of legal guardianship. When asked about R56's DD/RC diagnoses, SW-D stated there was some indication of a learning disability, but she did not see anything in her record identifying an actual DD diagnosis. However, as the conversation progressed, SW-D mentioned some psychological testing that was completed for R56 approximately six months prior. Upon further inquiry, SW-D stated the testing identified an intelligence quotient (IQ) of 63 and included a notation of moderate intellectual disability. Review of a Psychological Interpretive Report signed 3/25/15, detailed assessment and psychological testing that was completed on R56 at Nystrom & Associates, Ltd by licensed psychologist (LP)-A. The report detailed R56 had a Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), full scale IQ of 63, with a resulting diagnosis of moderate intellectual disability. Although R56 had two separate PASRR screening completed by two different individuals, the facility did not contact the county agency to clarify the discrepancy between the two PASRR, to determine if R56 needed a level 2 PASRR screen completed. A facility policy regarding PASRR screenings was requested, but was not provided.	F 285		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		12/29/15

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F 309	Continued From page 43 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce pain for 1 of 3 residents (R118) reviewed for pain. R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change. The facility also failed to provide proper wheelchair positioning for 1 of 1 residents (R57) who was leaning significantly to the right side. Findings include: PAIN: R118's undated Resident Admission Record identified diagnoses including peripheral vascular disease (PVD), osteoarthritis in right hip, cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg non-healing with an infection, chronic pain syndrome, and Trigeminal Neuralgia (nerve pain). The admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and she required limited assistance for most activities of daily living (ADLs). The MDS identified R118 did not receive scheduled pain medication, but received as needed (PRN) pain medication and non-pharmacological interventions for pain management. The MDS identified the pain made it difficult to sleep at	F 309	F309-G Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure residents receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 118 had comprehensive pain assessment completed, and medical provider was contacted multiple times for changes in pain management. Resident was hospitalized on 17 Nov 15 for wound assessment and treatment. Upon return from the hospital, a pain assessment was	

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F 309	Continued From page 44 night, and limed her day to day activity. A self-reported numerical pain rating scale identified her current pain was a nine out of 10 (a zero (0) to 10, numeric pain rating scale of 0 = no pain, 10 = the most intense pain imaginable). Her pain was identified as frequent, but did not include a verbal description of the pain even though the MDS identified she had one arterial or venous ulcer at the time of the MDS. The Care Area Assessment (CAA) dated 8/24/15, identified R118 needed assistance with all ADLs due to weakness and decreased mobility from osteoarthritis, but wanted to do as much for herself as possible. The CAA identified R118 had a stasis ulcer on her right leg that was infected and continued to drain large amounts of fluid. The CAA identified R118, "Is complaining of pain due to neuropathy, osteoarthritis, and stasis ulcer on right lower leg. States that PRN Tramadol [Ultram, an analgesic medication] relieves pain. Also uses warm towels and repositioning. Staff will continue to monitor for pain and update MD [medical doctor] as needed." Although the MDS identified R118 had pain, which made it difficult to sleep, and limited her day to day activity, the facility had not assessed this area to determine if the pain regime was appropriate for R118. The care plan dated 10/9/15, identified R118 was at risk for uncontrolled pain related to osteoarthritis and stasis ulcer to her right lower extremity. The care plan goal was for R118 to state her pain was decreased with the use of an analgesic, or show non-verbal signs of decreased pain. Interventions included the following: ·Encourage R118 to report pain levels PRN, per a numeric scale as able.	F 309	completed and Care Plan was updated to reflect resident pain goals and individualized interventions. Resident 57 had Occupational Therapy, evaluation completed for positioning with changes to plan of care with a follow up Occupational Therapy evaluation for adaptations for comfort and skin. 2.Actions taken to identify other potential residents having similar occurrences: All residents have the potential for pain. All residents with identified pain will have their assessment and pain management reviewed, to ensure they have proper pain control. All residents in wheelchairs will be observed for proper positioning. 3.Measures put in place to ensure deficient practice does not recur: Staff will be educated on pain identification and management and licensed nurses will be educated on the Pain Observation by 13 Dec 15. Residents will be routinely assessed for pain using the eMAR system. MDSs will be completed upon admission, quarterly and with significant changes to include a comprehensive pain assessment. Care staff will be educated on wheel chair positioning and follow-up by 13 Dec 15. Facility has implemented daily IDT stand up meetings starting 30 Dec 15 to monitor for potential residents with pain and w/c positioning concerns. 4.Effective implementation of actions will be monitored by:	

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F 309	Continued From page 45 ·Administer medications to R118, routine and PRN, as ordered for pain. ·Monitor R118 for changes in comfort PRN, reassessing her pain as needed. ·Offer R118 comfort measures PRN, of repositioning, heat, cold, massage, diversional activities, etc... During observation and interview on 10/21/15, at 11:30 a.m. R118 complained of unmanaged pain related to an open sore to her right, lower leg. She stated a routine dressing change had just been completed to her right leg and reported the pain she experienced during these dressing changes was excessive, stating her pain "hits over a 10." R118 stated if the nurses think of giving her pain medication before and after the dressing change they will, along with some ice. The ice packs, and pain medication at times, "Will subside almost, and then all of the sudden it is like a grabbing pain that almost sends me through the ceiling." During this conversation, R118 was frequently rubbing her right, lower leg and applying ice packs to the area. R118 stated her current pain level was,"down to a five [5] ... it is tolerable." R118 reported a pain rating of 5 was an acceptable level of pain for her. On 10/22/15, at 9:28 a.m. R118 was observed in her room, receiving her morning medications from licensed practical nurse (LPN)-F. Both LPN-F and R118 confirmed she had just received a pain medication (Gabapentin 300 mg, pain medication to treat nerve pain) and she typically liked to wait "for her pain pill to kick in," before her dressing change was completed. R118 asked LPN-F to return in a half hour to complete her dressing change and to bring an ice pack. At 10:01 a.m., R118 stated, "[Her pain medication]	F 309	Facility will complete five NAR Care Observations weekly and facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Ten chart audits will be done monthly for three months for pain management. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	

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never quite cuts it... when they start scraping, there's nothing [that could stop the pain]." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m. LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, it's starting to burn." LPN-F asked

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F 309	Continued From page 47 R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated, "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118. During interview on 10/22/15, at 10:51 a.m. LPN-F confirmed the verbal and non-verbal pain indicators she observed, which was a typical reaction during her dressing changes. LPN-F reported R118's doctor and nurse practitioner were aware of these symptoms. LPN-F stated R118's pain management regimen consisted of offering Ultram first, then oxycodone if the Ultram was not effective. LPN-F added, she could also have ice at any time and this has been the same pain management regimen for R118 for some time. She was not sure what the rational of the physician was, for not making further changes to the pain medicaiton regimen. LPN-F stated, She	F 309		

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trys to give her (R118) time when she removed the dressing, so she (R118) can take a breath and "get her bearings" and will then continue when she is ready.

R118's current physician orders dated 10/26/15, directed the following wound treatment and pain management regimen:
·Wound treatment to stasis ulceration on right lower extremity- cleanse wound, apply Silversorb, cover with ABD pad and Kerlix, change dressing daily and PRN.
·Gabapentin 300 milligrams (mg), twice daily for peripheral neuropathy/ polyneuropathy.
·Ultram 50 mg, every four hours PRN for pain, for chronic pain syndrome.
·Oxycodone 5 mg, every four hours PRN for pain not relieved by Ultram, for chronic pain syndrome.

Review of R118's physician progress notes from 8/17/15, to 10/26/15, identified the following:
R118's New Patient History and Physical Examination, completed by medical doctor (MD)-A and dated 9/3/15, noted she had osteoarthritis affecting her knees, shoulder and hip, with residual pain post knee and hip arthroplasties. The report did not further address her pain.
On 8/24/15, nurse practitioner (NP)-A noted R118 had complaints of pain to her right lower extremity with dressing changes.
On 9/10/15, NP-A noted the appearance of R118's right lower leg and reviewed the dressing treatments. NP-A noted, "Discussed pain control will add oxycodone for mod [moderate]/severe pain."
On 9/23/15, a Wound Care/ Hyperbaric Medicine History and Physical noted, "There is a wound on the anteromedial portion of [R118's] right lower

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leg. This measures 11 x [by] 12.5 x 0.1 cm [centimeters]. The wound is about 60% yellow fibrin and 40% pale red. It is very tender to touch and I am unable to do any sort of debridment on it. It does not appear to be infected... I initially tried to dress the patient's wound with Medihoney; however, the patient developed a lot of discomfort with this. My initial inclination had been to treat it with lodosorb in an attempt to control drainage but the patient was afraid that that would be painful... She did receive a dose of oxycodone here and once her pain got better her wound was then dressed..."
On 10/8/15, NP-A addressed R118's chronic right lower leg ulcer. NP-A noted, "Resident today says, 'I'm ok,' but frowning and awaiting R [right] LE [lower extremity] dressing [change]. C/o [Complains of] pain to R LE. Refuses to go back to Monticello Wound Clinic- 'They don't know nothing.' She is very particular about what she will allow to be put on R LE wound... looks unhappy- waiting for dressing [change]." The note directed no change to the wound treatment and to continue with antibiotic treatment for cellulitis through 10/12/15.
On 10/19/15, NP-A noted R118's emergency room visit was reviewed. The note did not address R118's stasis ulcer.
No further assessment, description, or plan for pain management were included in the physician progress notes.

Review of R118's Electronic Medication Administration Record (EMAR) from 9/1/15, to 10/25/15, identified the following as PRN pain medications were administered for right, lower extremity and leg pain.

The September 2015 EMAR identified R118 took

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a total of 103 doses of PRN pain medication. She took 68 doses of Ultram 50mg, which were effective 42 of 68 opportunities; slightly effective 14 of 68; not effective 2 of 68, and other, which was not identified for 1 of 68 opportunities.

R118 had 35 doses of PRN oxycodone 5mg in September 2015, which was effective 14 out of 35 opportunities; slightly effective 3 out of 35; and other which was not identified 3 out of 35, opportunities.

The October 2015 EMAR identified R118 was administered 100 doses of pain medication for right, lower extremity leg pain. She took 49 doses of Ultram 50mg, which was effective 18 out of 49 opportunities; slightly effective 17 out of 49; and not effective 6 out of 49 opportunities.

R118 had 51 doses of PRN oxycodone 5mg, in October 2015 which was effective 34 out of 51 opportunities; slightly effective 11 out of 51; not effective 5 out of 51 and other, which was not identified, 1 out of 51 opportunities.

Review of the EMAR PRN administration times from September to October 2015, did not correlate with R118's dressing changes, because the dressing changes were not consistently documented.

Even though R118 was administered 203 doses of PRN pain medication, taken in 55 days, approximately 3.7 doses of PRN pain medication each day, along with her scheduled Gabapentin 300 mg twice a day. R118 continued to experience significant pain with her dressing changes.

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F 309	Continued From page 51 Review of R118's nursing progress notes from 8/17/15, through 10/26/15, identified complaints of pain for R118: On 8/24/15, at 10:18 p.m. LPN-G noted, "Changed dressing on lower right leg ... About an hour later Resident had c/o a 'burning pain.' Writer asked if a pain pill would help or if it was too much and it needed to be taken off? Resident asked for it to be taken off. Writer took off dressing... cleaned wound and only applied Bacitracin with non-stick dressing then covered with ABD and wrapped with Kerlix. Resident has not have any further c/o pain but is requesting that she receive something else on the wound that won't burn." On 8/27/15, at 1:09 a.m. LPN-D noted, "[R118] rates pain 8/10; ...per resident alginate dressing 'burns' refused to have on skin; ...communication being sent to update PMD [primary medical doctor]." On 8/27/15, at 10:23 a.m. LPN-F noted, "Leg dressing changed... Area continues to be red, macerated et [and] tender to the touch... Resident claims the wound spray hurts her when use for washing wound. Resident refused it to be used on her D/T [due to] reported pain." On 9/6/15, at 10:48 p.m. LPN-D noted, "[R118] c/o pain in RLE... dressing removed per [R118's] request; cool cloth applied with some relief; leg has been elevated; will reassess in one hour when may have prn pain medication." On 9/7/15, at 1:39 p.m. registered nurse (RN)-C noted, "[R118] refused to have dressing put on in fear that it would start hurting again... [R118] is leaving it open to air. PRN given." On 9/8/15, 2:28 p.m. LPN-B noted, "Writer called the on call MD/NP and left a message regarding resident's wound on her leg. Resident is refusing to let staff place a dressing on her leg per	F 309		

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orders."
On 9/8/15, 11:10 p.m. LPN-C noted, "[R118] c/o pain to RLE. [R118] is unable to have any more prn pain medication for another 2 [two] hours. On call physician... said to use standing order of Tylenol. Will administer Tylenol and continue to monitor."
On 9/13/15, at 12:25 p.m. LPN-B noted, "... [R118] does c/o pain during a.m. dressing change... PRN pain medication given x [times] 2 at this time."
On 9/19/15, at 1:12 a.m. LPN- D noted, "[R118] c/o 7/10 pain right lower extremity; somewhat relieved with prn Tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]."
On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, 'It burns so bad when drainage is left on my leg.'"
On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds were given closer together. Resident has been seen by NP. Area on leg measures 16 cm x 10 cm draining et macerated with some greenish color at first change when NP was in room."
On 10/12/15, 2:27 p.m. LPN-F noted, "[R118] continues to c/o pain. PRN pain meds given x 2. Resident makes requests for dressing changes. Leg continues to be painful et macerated during dressing changes."
On 10/15/15, at 12:09 p.m. LPN-J noted, "Treatment completed to RLE... C/o pain while treatment is being completed, had received pain med prior to tx [treatment] being done. States that it hurts when it is open to air."
On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication."

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F 309	Continued From page 53 During interview on 10/26/15, at 10:42 a.m. nursing assistant (NA)-A stated, R118 has pain in her legs and she had seen her "pretty upset and crying." NA-A stated has seen R118 in pain and/or has complained of pain to her almost daily. NA-A stated she told the facility nurses when R118 complained of and/or appeared in pain, to see if she could be given any pain medication. NA-A stated the pain medications seemed "somewhat effective, [but] never 100% [effective]." During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's pain was mainly in her right lower leg, where she had an open area. RN-H stated the area has been improving, but was taking a long time. Upon review of the EMAR, RN-H reported R118's pain rating was typically around an 8 (0-10 pain scale) prior to receipt of her PRN pain medications. She reported R118's physician was at the facility every Thursday and was responsible for monitoring to ensure her pain management regimen was sufficiently effective. RN-H stated the most recent notation of the physician/ nurse practitioner commenting on her pain was the physician's progress notes, on 10/8/15. RN-H reported R118 had attended a wound clinic, but stopped going after 9/23/15, because she was very upset and did not want to go there anymore. RN-H stated she had spoken to R118 about her pain, as recently as 10/14/15, and she had indicated satisfaction with her pain management regimen. Upon inquiry as to R118's acceptable level of pain, RN-H replied she was unsure. RN-H stated that she was aware R118 had significant pain with dressing changes, but believed the current pain management regimen was effective for her. She	F 309		

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stated the nature of R118's wound was going to result in some, inevitable pain during dressing changes. However, when told of the observed dressing change on 10/22/15, RN-H denied knowledge of R118 having reactions to that extreme. RN-H stated, "If she [R118] is saying she is having that much pain, she is having that much pain." RN-H denied any reports of pain concerns for R118, from the facility nurses or NAs. RN-H stated, she expected staff would have updated the physician if/when they identified unmanaged pain, as the physician could have looked at getting an increase in R118's pain medication. RN-H stated R118's use of the ice pack was typical, however, "If that was what we were seeing, then that would not be a sufficient management of her pain." RN-H confirmed, R118's pain should have been reassessed. RN-H confirmed the facility used section J of the MDS as their sole pain assessment, which was only completed on a quarterly basis.

During interview on 10/26/15, at 5:11 p.m. the director of nursing (DON) stated she gas completed R118's dressing changes on a frequent basis. She made sure R118 was medicated about one hour before the dressing change and asked her (R118) frequently throughout the dressing change, how she was doing. The DON stated she soaked the Silversorb in a significant amount of normal saline to keep it from sticking to her leg and made sure she had an ice pack to use for her leg at the time of dressing change. The DON stated she typically looked at R118 and tried to get her to laugh, distracting her during the dressing change. The DON stated she felt these interventions were "as effective as they can be." The DON stated, when R118 was first admitted to the facility, the

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dressing changes were much more painful than they were presently. The DON stated she had never seen R118 cry during a dressing change and upon discussion of the observed dressing change (10/22/2015), she denied having seen that kind of response from R118 any time she had completed or observed her dressing changes. The DON stated she expected some discomfort with this type of dressing change, but if R118 had demonstrated significant signs of pain as identified in the 10/22/15 observation, she expected the nurses to document this in the medical record and see what they could do about getting some different analgesic medications for her.

Although R118, had a stasis ulcer, had frequent progress notes that identified significant pain, and had nurses and nursing assistants who observed R118 in pain, either during her dressing changes or other times during the day. R118 only received Gabapentin 300 mg twice a day, for a routine scheduled pain medication, and Ultram 50 mg PRN for pain and oxycodone 5 mg PRN for moderate to severe pain. R118 only received the Gabapentin 300 mg prior to her dressing change in the morning of 10/22/2015, and then received oxycodone 5mg after the dressing change was completed. Even though R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change. The facility did not comprehensively assess and developed an appropriate pain management interventions to assist in reducing her pain.

The facility's Dressing Change, Clean policy dated 6/14, directed nursing to check physician orders to see if a resident required an analgesic prior to completion of dressing changes and to

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administer any analgesic medication as ordered. The policy did not further address pain management during dressing changes. Facility policies regarding pain management with dressing changes were requested, but no additional policies were provided.
WHEEL CHAIR POSITIONING:

R57's quarterly MDS dated 9/22/15, identified R57 used a wheelchair for mobility, and required extensive assistance with activities of daily living (ADLs). R57's care area assessment dated 4/21/15, indicated she had contractures, and limited range of motion. R57's care plan dated 9/23/15, indicated alterations in mobility related to increasing weakness and directed staff to refer to physical and occupational therapy as needed.

A Resident Progress Noted dated 9/13/15, indicated "pillow given to resident on wheel chair due to resident leaning to right." A Resident Progress Note dated 9/5/15, indicated R57 was up in wheel chair and would "drift off, leaning to right."

During and observation on 10/19/15, at 8:16 p.m., R57 was sitting in a wheel chair. She appeared to be sleeping with her head resting on her right arm, leaning to her right. On 10/20/15 at 9:58 a.m., R57 was again observed sitting in her wheel chair, leaning to her right side. On 10/21/15, at 8:58 a.m., R57 was leaning to her right side in her wheel chair with her head resting on her tray table. On 10/23/15, at 3:55 p.m., R57 was observed sitting in her wheel chair, leaning to her right side with her head resting on a pillow that was placed on the right arm rest of her wheel chair. Although R57 continued to lean to the right, there were no supports noted in her wheelchair to

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support her trunk that prevented her from leaning.

During and interview on 10/23/15, at 11:32 a.m., NA-B stated R57 refuses to lay down a lot of the time, that's why we put pillow by her head. NA-B further stated R57 "has always leaned to the right side, not sure why that is."

During an interview on 10/23/15, at 11:48 a.m., occupational therapy assistant (OTA)-J stated R57 was recently given a right lateral support for her wheel chair. OTA-J stated R57 was seen for a referral "about a month or so ago," but was not picked up for ongoing therapy. He felt R57's chair size was appropriate but that (R57) was more fatigued.

During an interview on 10/26/15, at 1:53 p.m., NA-T stated, R57 is like that "all the time," they get her up for breakfast and then she falls asleep in her wheel chair. NA-T further stated, she used to lean a little but her leaning has been going on for the past few weeks.

During an interview on 10/26/15, at 2:07 p.m., LPN-H stated, some they they have difficulty getting her (R57) to lay down. Sometimes they will place a pillow under her head to buffer the uncomfortable position but, "she always looks like that." LPN-H further stated, she though this was her second chair, and was unsure if (R57) had lateral supports or if they helped or not. R57 was at high risk for falling out of her chair because she is always leaning to her right. LPN-H further stated, R57 had been screened by occupational therapy for positioning, but was unsure if she had been re-evaluated.

During an interview on 10/26/15, at 2:32 p.m.,

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F 309	Continued From page 58 occupational therapist (OT)-K and OTA-J stated, they had received a referral in September for R57 because of her leaning and gave her a lateral supports. They also recommended she (R57) lie down if tired and listed the potential for several negative outcomes of a sore back, and neck. At the time of the referral in September 2015, the lateral support was providing R57 with the amount of assistance she needed to sit up right and be able to propel herself in her wheel chair. OT-K and OTA-J further stated, R57 was "never leaning that bad when we saw her" and that her current positioning was a change and she should have been referred back to therapy for an evaluation. A policy addressing positioning for residents was requested, but was not provided.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care.	F 312	F312-E Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and	12/29/15

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F 312	Continued From page 59 Findings include: LACK OF NAIL CARE: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete her personal hygiene. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room. R5 had visibly long fingernails on both hands with a dark colored substance underneath several of the nails. R5 stated he was diabetic so "not everybody can cut them", but added his preference would be to have shorter nails. On 10/22/15, at 9:01 a.m. R5 continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. nursing assistant (NA)-T stated R5 seldom refused cares or assistance from staff, and nail care was to be completed on residents scheduled bath days. At 2:03 p.m. NA-T observed R5's nails and stated they were too long, and "not very clean underneath." Further, NA-T stated they were unaware of any preference of R5 to have long, dirty fingernails and they should be trimmed. During interview on 10/22/15, at 2:33 p.m. licensed practical nurse (LPN)-A observed R5's long, dirty fingernails and stated "they need to be cut." Further, LPN-A stated R5 was dependent on nursing staff for his nail care, and his nails should have been trimmed and cleaned on his bath day. When interviewed on 10/23/15, at 11:23 a.m.	F 312	it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to provide the necessary services to maintain good nutrition, grooming and personal and oral hygiene. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: On 22 Oct 15, after Resident 5 refused, nurse was able to trim resident's nails. Resident 5 and Resident 64 nails were audited and were cleaned and trimmed. An interview with resident to obtain preferences completed on Resident 126 and was offered alternative options of chux, disposable products etc . Resident stated it was his desire to continue use of newspaper to enhance independence, but with improved health condition he did not feel this would be needed any longer. Resident stated with condition improvement he is now using commode at bedside for most all toileting needs. Resident and NAR Care Guide updated to reflect residents preferences for maintaining as much independence as possible. Resident 19 received their bath on 27 Oct 15. Resident 45 received their bath on 28	

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F 312	Continued From page 60 registered nurse (RN)-A stated R5 required assistance to complete his nail care, and his nails should have been cleaned and trimmed, "[They] should be taken care of when they get their bath done." R64's quarterly MDS dated 9/15/15, identified R64 had moderate cognitive impairment, and required extensive assistance from staff to complete his personal hygiene. During observation on 10/20/15, at 9:36 a.m. R64 was seated in a standard wheelchair in his room. R64 had visibly long fingernails with several nails having a dark colored substance underneath several nails. R64 stated he preferred to have shorter kept nails adding they "could use a clip." On 10/22/15, at 9:04 a.m. R64 was seated in his wheelchair outside his room, and continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. NA-T stated R64 had never refused cares or staff assistance to their knowledge. At 2:03 p.m. NA-T observed R64's nails and stated they were "very long" and should be cleaned and trimmed. During interview on 10/22/15, at 2:33 p.m. LPN-A observed R64's nails and stated they should have been cleaned and trimmed on his bath day. When interview on 10/23/15, at 11:23 a.m. RN-A stated R64 had no desired preference to have long, dirty fingernails and they should have been cleaned and trimmed on his bath day. A facility policy on grooming and nail care was requested, but none was provided.	F 312	Oct 15. Resident 19 and Resident 45 will be interviewed for bathing preferences by 13 Dec 15. 2.Actions taken to identify other potential residents having similar occurrences: All resident's nails were observed to ensure nails were trimmed. Random audits on incontinent residents to ensure timely assistance with toileting based on assessed needs. Residents were interviewed using a modified CMS Resident QIS Interview tool to include bathing preferences. Audits completed to ensure residents receive timely bathing. 3.Measures put in place to ensure deficient practice does not recur: Care staff education completed and training content included completing resident cares (nail care, toileting, and bathing) and following resident care plan. Facility revised process for interviewing residents about bathing/showering preferences upon admit and with comprehensive RAI reviews. Facility process and procedure for bathing was review and revised. Care staff and Activities educated on change of practice with bathing preferences and honoring Resident Choices by 13 Dec 15. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS	

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F 312	Continued From page 61 LACK OF BATHING: R45's annual MDS dated 8/11/15, identified R45 had intact cognition, and required physical assistance from staff to complete her bathing. During interview on 10/22/15, at 1:46 p.m. R45 stated she does not always receive her schedule bath because of the facility being short staffed. Further, R45 stated not receiving her bath consistently makes her "angry", and she would like to have her bathing completed. Facility Lakeside Oasis Bath Records dated 9/14/15 to 10/21/15 were reviewed. The records were constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. R45's name was identified on the records, however for three weeks there were no staff initials identified next to her name to identify she received bathing. The spaces provided to record initials were left blank. When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R45 enjoyed her showers, but added they were sometimes not completed due to a lack of staff to complete them. During interview on 10/23/15, at 11:59 a.m. RN-A stated she was not aware R45 was not receiving her baths as scheduled, but added it "wouldn't surprise me." Further, RN-A stated R45 should have been given her baths as scheduled.	F 312	Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. 10 timing audits for toileting will be completed each month for three months. 10 bathing audits will be completed monthly for three months. The data collected will be presented to the Quality Assurance and Assessment Committee quarterly. At that time the Quality Assurance and Assessment Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	

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F 312	Continued From page 62 R19's quarterly MDS dated 9/29/15, identified R19 had intact cognition, and required assistance from at least two staff to complete her bathing. During interview on 10/22/15, at 2:11 p.m. R19 stated she was supposed to receive a bath twice a week, but had to go without her baths at times because there was "not hear enough" staff at the facility. Further, R19 stated she wanted to receive all of her scheduled baths as it was "very" important to her. A facility Mill Creek Bridge Weekly Bath and Vital List dated 8/3/15 to 10/21/15, identified R19 was scheduled for a bath twice a week. The listing was constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. However, R19 was not provided her baths for four of sixteen scheduled times according to the record. When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R19 enjoys her baths, but added some have been missed because there were no staff available to complete it. During interview on 10/23/15, at 11:59 a.m. RN-A stated her expectation was for staff to complete bathing as required for residents. A facility policy on bathing was requested, but none was provided. LACK OF TIMELY PERICARE: R126's admission Minimum Data Set (MDS) dated 9/25/15, identified R126 had intact cognition, required extensive assistance for	F 312		

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F 312	Continued From page 63	F 312		

toileting and personal hygiene, and was continent of bowel.

R126's care plan dated 10/12/15, identified R126 had an alteration in his elimination related to decreased mobility, but remained continent of bowel. Further, the care plan directed staff to complete, "Pericare with assist of 1 with am [morning] and HS [hour of sleep] cares." The care plan did not identify if or when pericare should be completed for toileting not associcated with those set times.

During interview on 10/20/15, at 3:22 p.m. R126 stated he was dependent on staff for help with pericares after having a bowel movement, however he did not always recieve timely assistance with this. R126 used a bed pan, but stated his bottom would ge sore if he sat on it for too long, so he would remove himself from the bed pan, and place newspaper underneath of himself to prevent the bed linens from becoming soiled while he waited for staff assistance with pericares.

When interviewed on 10/26/15, at 10:27 a.m. nursing assistant (NA)-A stated she had assisted R126 with toileting and pericares before, and noticed feces soiled newspaper on his bed before. NA-A stated she was unaware R126 was using it as a barrier to prevent the linens from becoming soiled while waiting for staff assistance.

During interview on 10/26/15, at 2:18 p.m. registered nurse (RN)-H stated she was unaware R126 was using the newspaper after having a bowel movement while he waited for assistance with pericares.

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F 312	Continued From page 64 A letter submitted post survey exit dated 10/28/15, authored by NA-T noted, "A couple of times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put himself on bedpan, notifying staff only when he was done." A letter submitted post survey exit, dated 10/30/15, authored by NA-D noted, "[R126] chose to use newspaper under himself even though I told him he didn't need to do that and we would change linen if it got soiled. He continued to put newspapers under him." A facility policy on toileting and pericare was requested, but none was provided.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote urinary continence for 1 of 3 residents (R64)	F 315	F315-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response	12/29/15

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F 315	Continued From page 65 reviewed for urinary incontinence. Findings include: R64's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R64 had moderate cognitive impairment, required extensive assistance with toileting and was, "Always incontinent" of bladder. R64's Nursing Observations 3.0 Assessment dated 9/18/15, identified R64 to be "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." The assessment did not identify if any or what type of a toileting program needed to be implemented for R64, to decrease R64's incontinence. R64's care plan dated 9/21/15, identified R64 had an, "Alteration in elimination r/t [related to] weakness following hospitalization", but R64 was, "Aware of the need to void/defecate." Further, the care plan directed staff to, "Toilet per request", and, "Monitor for changes in elimination patterns and reassess quarterly and prn [per request or as needed]." During interview on 10/22/15, at 9:43 a.m. nursing assistant (NA)-T stated he helps R64 to the bathroom when he requests as care planned, but has noticed R64 to be "more incontinent of urine" lately. Further, NA-T was unaware of any set toileting schedule for R64. During observation of care on 10/23/15, at 7:24 a.m. R64 was assisted to the toilet by NA-F. NA-F removed a visibly soiled white incontinence pad from R64, and placed it in the trash stating R64, "Had the wrong kind of pad on." R64 should	F 315	and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to comprehensively assess and develop interventions for promote urinary continence. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 64 will have a comprehensive toileting assessment completed and the care plan updated. 2.Actions taken to identify other potential residents having similar occurrences: Based on software reports and information gathered from daily IDT meetings, all residents that are incontinent are at risk from this deficient practice. Incontinent residents bladder assessments will be reviewed to ensure individualized toileting plans match resident needs with MDSs upon admission, quarterly and with significant changes. 3.Measures put in place to ensure deficient practice does not recur:	

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F 315	Continued From page 66 have had an "extra absorbent" green colored pad on during the night to help reduce irritation to his skin from being incontinent. NA-F stated R64's removed incontinence pad "was full" of urine, as R64 was typically incontinent in the morning, but when assisted to the toilet would sometimes void. Further, NA-F stated R64 was unable to verbalize when he needed to use the restroom, so she helped him "every two hours" to the restroom. During interview on 10/23/15, at 11:34 a.m. registered nurse (RN)-A stated R64 was able to voice his need to use the restroom, "Most of the time", and should be helped with toileting every two hours. R64 should not be incontinence of urine, "More than a couple times a day," with his toileting ability, and the assessment completed on 9/18/15 should have identified a toileting program for R64 to promote continence. Although R64's assessment identified him as "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." There was no indication if R64 needed a scheduled toileting program, or was a check and change (no attempts to place on the toilet) even though R64 had been using the toilet, and NA-F stated he did have some continent voids. A facility policy on urinary incontinence was requested, but none was provided.	F 315	Facility practices on Care Planning and Toileting were reviewed and revised, as needed, with education provided to licensed staff by 13 Dec 15. Daily IDT meetings were established on 30 Oct 15 to also aid in capturing residents potentially at risk. MDS's will be completed upon admission, quarterly and with significant changes, to determine the individualized toileting program. 4.Effective implementation of actions will be monitored by: Facility will complete five NAR Care Observations weekly for three months. Ten chart audits will be done monthly for three months for individualized toileting program. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		12/29/15

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F 333	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 1 residents (R45) who had a medication error in which they received the incorrect dosage of insulin that caused low blood sugars with physical symptoms. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated the resident was cognitively intact, had diagnoses of diabetes mellitus, and received daily insulin injections. Review of the Buffalo Clinic Telephone order report dated 4/8/15, indicated the facility was instructed by the clinic to notify the physician if R45 had blood sugars below 80 milligram/deciliters (mg/dl), normal blood sugar range 80-120 mg/dl. Review of the Allina Health Clinic Buffalo note which included physician orders dated 4/16/15, indicated R45 was to, "Continue Lantus [long acting insulin] as of the last dosage which was 37 units in the morning. No night time dosage for now." The Lake Ridge Care Center signed Physician Order (PO) Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. The PO did not direct staff to give a night time dose of Lantus. An Allina Health office visit note dated 4/20/15, indicated R45 was to go, "Back on lantus 37 units	F 333	F333-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure that residents are free of any significant medication errors. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 45's insulin order clarified by medical provider on 27 Apr 15. Nurses and HUC were identified that were responsible for transcription of the insulin. Medication error event was created. HUC received education on Medication error and transcription; both nurses are no longer employed at facility. 2.Actions taken to identify other potential residents having similar occurrences: All residents who receive insulin are potentially at risk from this deficiency.	

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F 333	Continued From page 68 at bedtime." However, there was no indication R45 had been receiving Lantus at bedtime prior, as the resident had only been taking Lantus 37 units in the morning. Although this PO added 37 units more of insulin, than R45 was currently receiving. The facility did not clarify the significant increase in insulin R45 was to receive from the Allina physician. Review of R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in the morning. However, on 4/20/15, Lantus at HS (at bed time), was implemented, along with the Lantus 37 units in the morning; doubling R45's dose of insulin. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15, to 4/26/15. Review of R45's Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45's blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/25/15, indicated the residents blood glucose was checked when the resident was eating breakfast and was only 51 mg/dl. Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/26/15, at 3:30 a.m. indicated the residents blood glucose was 51 mg/dl. Review of the medical record did	F 333	Residents who receive insulin will be identified and medical provider orders verified for accuracy against eMAR. 3.Measures put in place to ensure deficient practice does not recur: Licensed staff and HUCs will receive education on diabetes, transcription and medication orders by 13 Dec 15. Facility procedure for transcription and medication errors reviewed and revised; orders will be verified by licensed nurse after transcription. 4.Effective implementation of actions will be monitored by: Five residents who have insulin orders will have MD orders verified against eMAR monthly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15.

R45's Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated, "Resident had low BS (blood sugar) this morning; was sweating and shaky. She had a BS of 38." The physician was called at 8:44 a.m. and updated on R45's low blood sugar.

A Buffalo Clinic Telephone Communication sheet indicated on 4/27/15, at 8:42 a.m. Lake Ridge called the clinic regarding R45's low BS in morning of 38 mg/dl. The Telephone Communication form indicated at 4:46 p.m. Lake Ridge called the clinic back wanting to know if the patient should actually be on 37 units of Lantus at bed time, as the facility just noticed the insulin orders did not match up.

A Buffalo Clinic Telephone order report dated 4/27/15, medical doctor (MD)-B indicated at 5:34 p.m., "Discussed with [staff] by phone. As of 4/20/15, visit had written to return to Lantus 37 units at bedtime, when it should have been once daily MORNING DOSE> Clarified with [staff] patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." MD-B ordered Lantus 37 units once daily in the morning as prior to hospital stay.

R45's Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated, "Resident had been receiving Lantus 37 units BID (twice daily) since 4/20, miscommunication written upon return from appointment. Spoke with [MD-B] and the HS dose has been d/c'd [discontinued] and will continue the 37 units in AM (disregard previous T.O. (telephone order)."

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F 333	Continued From page 70 During interview 10/26/15, at 9:30 a.m. director of nursing (DON) stated she was not aware of the insulin medication error that had occurred for R45, and stated she was unable to locate a medication error report. The DON stated the nurses should have called the physician when they noted the order for Lantus to be given at HS on 4/20/15, since the resident had not received that dose before, and the order was doubling the current insulin she was receiving. The DON stated that she had not checked any other residents orders to see if this was reoccurring problem. DON stated she did not do any staff training related to the significant medication error, because she was not aware the error occurred until survey on 10/26/15, six months after the error occurred. Although R45 was previously on Lantus 37 units in morning only, and had a history of low BS after the order to double the residents insulin dose on 4/20/15, the facility failed to clarify with the physician the additional order of Lantus 37 units at HS, nor did the facility contact the physician when R45 had low blood sugars on 4/22/15, 4/25/15, and 4/26/15. The facility did not contact the physician until 4/27/15, 7 days after R45's insulin dose was doubled, when the resident had a low blood sugar of 38 and experienced symptoms. Also, there was no indication they looked at other residents, and educated staff to prevent other potential medicaiton errors.	F 333		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or	F 353		12/29/15

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F 353	Continued From page 71 maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K,	F 353	F353-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center	

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F 353	Continued From page 72 COTA-J, SM-A and SM-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents who currently resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: > Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. > Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. > Refer to F282: The facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. > Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. RESIDENT CONCERNS ABOUT STAFFING: R126's admission Minimum Data Set (MDS) dated 9/29/15, identified R126 had intact	F 353	to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: We have provided written plans of correction for F-tags F-241 for R126, F-242 for R73, F-244 for R27, R19, R45, R35, R21, F-282 for R5 and F-312 for R64, R44 and R19 relating to the care of these cited residents found in the findings of our most recent CMS-2567, and how we have and/or will address those respective issues. We will continue interview, select and train prospective nursing employees as they are available to provide the care needed to these cited residents. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected by these deficient practices. 3.Measures put in place to ensure deficient practice does not recur: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15; corporate HR will perform interviews and assist in hiring until open positions are filled, and selection of new employees will be done within the requirements of employment law. Nursing	

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F 353	Continued From page 73 cognition, and required extensive assistance to complete ADLs. During interview on 10/22/15, at 3:22 p.m. R126 stated he had to wait up to thirty minutes to have his call light answered to receive assistance with cares. R126 stated he needed staff assistance to use the restroom and get into his wheelchair, and he never knew how long it would take staff to answer his call light and that made him feel, "Anxious," and "Helpless." During a follow-up interview on 10/26/15, at 10:00 a.m. R126 stated his preference was to use a commode for toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He stated, he need help to get on and off the commode, but is unable to get onto the commode alone, and has to wait for staff to help. R126 reported he would have much rather used a commode for toileting and not a bed pan, because he doesn't get as "messy," But staff does not respond to his call light for assistance timely to help onto the commode, so he has to use the bedpan and not the commode, which he prefers to use. R55's quarterly MDS dated 9/15/15, identified R55 had moderate cognitive impairment, and required limited assistance from staff for ADLs. During interview on 10/20/15, at 9:13 a.m. R55 stated she often had to wait for extend periods of time to get help to the bathroom, and was frequently incontinent because of waiting for so long. R55 stated the facility needed more staff to help residents with their cares, "They just don't have the people to work."	F 353	schedules have been re-created, and are posted for two-week time periods or more, and any vacant positions are posted on the schedule. These vacant hours are available to current employees, and are also called in to a pool agency if they cannot be filled before the pay period begins. Variably, weekly orientations have also been implemented to assist in staff getting onto the floor. Bonuses have been and will continue to be offered to fill vacant shifts, as well as increased night differentials. Advertisements for nurses and nursing assistants have been and will continue to be placed in local papers and online sources, such as Indeed, until open positions are filled. Locations that provide nursing assistant programs have been contacted to let them know of any open positions and how we can partner together to attract more applicants. A suggestion box was put into use to solicit input from employees, as well as using annual reviews and the EQIC meeting to address potential job duty issues. All employees were educated on what we are doing to attract new employees. We are hoping to hire a staffing coordinator to assist in scheduling and shift replacement. To allow for the proper care of our residents, we have also added on a new position, Resident Concierge Representative, to help assist in the needs of our residents. 4.Effective implementation of actions will be monitored by: Open positions and vacant shifts will be recorded on the schedule and an	

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F 353	Continued From page 74 R85's quarterly MDS dated 9/1/15, identified R85 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:03 a.m. R85 stated the facility had been, "Short of staff," for the past two or three months. R85 stated staff takes, "Quite awhile" to answer his call light to provide assistance with cares, and it had, "Been a big annoyance." R118's admission MDS dated 8/24/15, identified R118 had intact cognition, and required limited assistance from staff to complete ADLs. During interview on 10/21/15, at 11:34 a.m. R118 stated staffing seems worst on the weekend and in the evenings. R118 had a dressing change that needed to be completed, however, the resident had to wait over 6 hours for staff to complete this which caused the dressing to become saturated and drip fluids. R5's quarterly MDS dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 9:11 a.m. R5 stated the facility did not have enough staff, and staff would often complain about being short staffed to him, and at times R5 had stated there was only one nurse working for an entire shift. R5 stated his call light will take, "Fifteen to twenty minutes," to get answered, and was once left on the commode for, "An hour and a half," before staff came to provide assistance.	F 353	explanation of how those open positions or vacant shifts were covered will be written in the nursing schedule. If a shift cannot be filled for some reason, the Director of Nursing will be contacted, and that contact, time and vacancy will be written in the nursing schedule book. The Director of Nursing will inform the Administrator weekly for two months of open nursing department positions and shifts unable to be filled and the course of action to fill those positions and shifts, and as needed thereafter. All-staff meetings will be held monthly for three months. Each Employee Quality Improvement Committee meeting will have adequate staffing levels added to the agenda, with reports continuing to be provided to the quarterly Quality Assurance and Assessment Committee, to provide a system of allowing employees to discuss staffing levels to see if they are successful or not; the minutes of those meetings will be posted in the employee lounge. Adequate staffing levels will be on the agenda for each care conference, with attending residents and families being able to comment on whether changes with staffing levels are successful or not. Reports of adequate staffing will be evaluated and PDSA models will be implemented to continuously improve and enhance staffing. This data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting and the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued.	

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F 353	Continued From page 75 R73's admission MDS dated 10/1/15, identified R73 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/21/15, at 10:55 a.m. R73 stated he had waited for nearly two hours in the past for staff assistance to go to bed and for his call light to be answered. R73 stated the staff are over worked and under staffed for the residents to be provided the necessary cares in the facility. R35's quarterly MDS dated 10/6/15, identified R35 had moderate cognitive impairment, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:29 a.m. R35 stated the facility staff worked short nearly all of the time, and there had been times R35 would have to wait to use the bathroom but was incontinent due to not receiving timely assistance from staff to get to the restroom. R123's admission MDS dated 10/15/15, identified R123 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 12:20 p.m. R123 stated she had waited for over an hour to get help to the restroom, causing her to, "Just use my diaper," which she stated made her, "Feel degraded." R27's quarterly MDS dated 9/22/15, identified	F 353	5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	

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R27 had intact cognition, and required extensive assistance from staff to complete ADLs.

During interview on 10/20/15, at 10:24 a.m. R27 stated she had waited for over an hour to have her call light answered to receive assistance, and the facility needed to have more staff to provide the cares the residents needed.

FAMILY COMPLAINT'S ABOUT STAFFING:

During interview on 10/21/15, at 11:31 a.m. family member (FM)-G stated they had visited their family member in the past and used the call light requesting staff assistance and "Waited, and waited, and waited," over twenty five minutes for staff to respond. There had been multiple occurrences of waiting for the call light to be answered, and FM-G stated, "It [long call light response times] concerns me." FM-G stated they had been told the owners of the facility felt they were "Adequately staffed," but stated she disagreed and the facility needed to add more staff to help residents with cares.

During interview on 10/26/15, at 10:01 a.m. FM-H stated he had noticed oral cares were frequently not being completed because of the lack of staff at the facility. The call light had taken over one hour to be answered in the past, and was especially worse on the weekends.

STAFF CONCERNS ABOUT STAFFING:

During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents

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with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed.

During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time."

During interview on 10/22/15, at 1:23 p.m. NA-I stated the staffing at the facility was, "Not good," and there was frequently only one or two NA's on each hallway to provide cares to the residents. The residents frequently had to wait, and call lights were not answered timely because of the lack of staffing, "They [residents] don't get the care they should get." NA-I stated several staff members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves.

During interview on 10/22/15, at 1:36 p.m. NA-C

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stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff.

During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing. NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed.

During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but "they expect" the floor staff to get the work done and only come onto the floor, "When you guys [state surveyors] are here."

During interview on 10/22/15, at 2:53 p.m.

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licensed practical nurse (LPN)-F stated staffing is "Not adequate," to care for the residents and their needs, and she was quitting her position at the facility because she valued her nursing license, and felt it was being put in jeopardy because of the lack of staffing and poor care being delivered as a result.

During interview on 10/23/15, at 7:07 a.m. LPN-B stated she felt the facility did not have enough staff to provide the necessary care to residents, and residents had to wait to get up for the day, and families voice frustration to the staff regarding the suffering care as a result of the poor staffing. LPN-B stated she recalled some dressing changes weren't completed because the nurse did not have time because they were busy trying to help provide the necessary care for the other residents.

During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was suffering overall. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked for floor staff's input on how to handle the short staffing situation.

During interview on 10/26/15, at 2:32 p.m. occupational therapist (OT)-K and occupational therapist assistance (OTA)-J stated the floor staff could use more help, and the biggest complaint they hear from residents was the lack of staffing and waiting, "Way too long for [call] lights," to be answered. OT-K and OTA-J stated they were not aware of any actions being taken by the facility to

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F 353	Continued From page 80 address the short staffing concerns. During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in people to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done, "because you guys [state surveyors] are here." During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix this. The facility LRCC (Lake Ridge Care Center) documents, which displayed the names of the staff working on the floor for each shift, dated 10/19/15, to 10/23/15, were reviewed. The document identified each unit of the facility (Oasis, Lake View Lane, Mill Creek Bridge, and Northwoods), and provided blank spaces in which	F 353		

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F 353	Continued From page 81 a staff members name was written to identify were they were scheduled to work. > On the AM shift, 10/19/15, the Oasis unit had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods each had open spaces identifying no staff were scheduled to work; and were left with just one nurse and one NA for each unit. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/20/15, the Oasis unit again had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods had open spaces with no staff names written in. Both units continued with just one nurse, and one NA working on the floor providing care for the residents. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/21/15, the Mill Creek Bridge had no NA displayed, only having a nurse assigned to provide care to the residents. Northwoods had one nurse and one NA to provide cares to the residents. The document identified seven of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/22/15, the Lake View Lane had no nurse identified, and only one NA. Mill Creek Bridge and Northwoods again each only had one nurse and one NA identified as providing cares. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/23/15, the Oasis unit had no staff name identified as being assigned to	F 353		

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work on the unit, and the Lake View Lane did not have a nurse identified. The document identified five of the thirteen spaces used to identify staff, to be blank.

On 10/26/15, at 5:06 p.m. the director of nursing (DON) stated, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON stated the facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. DON stated the facility's staffing shortage began around the end of summer when students returned to college, and there were also eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident was discharged. When asked whether the facility had identified or addressed concerns of residents who were not receiving baths or oral cares, DON stated, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups."

During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and

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F 353	Continued From page 83 if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		12/29/15

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F 356	Continued From page 84 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the daily staff posting was updated in a timely fashion at the start of each shift to reflect the actual employees working for each shift. This had potential to affect all 48 residents in the facility, staff, and visitors who wished to review the information. Findings include: During observation on 10/26/15, at 4:32 p.m. the Lake Ridge Care Center Report of Nursing Staff Directly Responsible for Resident Care posting was displayed in a hard plastic holder attached to the wall by the nursing station. The posting identified three registered nurses (RN), two licensed practical nurses (LPN), and four nursing assistants (NA) were working at the facility on 10/26/15, during the time period of "6:00 am to 6:00 pm." The bottom of the posting identified, "The number of staff on duty at any given time may fluctuate." A LRCC (Lake Ridge Care Center) daily staff assignment sheet dated 10/26/15, identified the names of the actual staff working on the floor. The sheet provided blank spaces for staff names	F 356	F356-C Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure that the daily posting of nursing hours is updated in a timely fashion at the start of each shift. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Daily staff posting will be updated in a timely fashion at the start of each shift.	

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LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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F 356	Continued From page 85 to be written with headings including, "RN", "Nurse of TMA [trained medication aide]", "LPN/TMA", and "NAR [nursing assistant, registered]." The sheet identified only two nurses (RN and LPN), although the posting indicated three RN's and two LPN's, and three NA's to be working on the floor, although the posting indicated four NA's on 10/26/15, during the "Day Shift 6a [am] - [to] 6p [pm]." The sheet had seven blank spaces left on the sheet with no staff names being identified. During interview on 10/26/15, at 5:35 p.m. LPN-A stated the night shift staff fills out the daily staff posting and displays it on the wall by the nursing station. When there are changes to the scheduled staff, it does not get updated to reflect the actual staff working on the floor, and she stated, "I don't think they [staff postings] ever get changed." During interview on 10/26/15, at 5:55 p.m. the director of nursing (DON) stated she was responsible to ensure the staff posting was correct and displayed timely. Once posted by the night shift, the posting was not updated to reflect the actual number of staff working on the floor, "Once its up, I kinda leave it." DON stated the posting should be updated timely and accurate at all times, "Because its a requirement." A facility Posting of Nursing Hours policy dated 12/10/14, identified the posting is completed and displayed, "Daily by the Clinical Coordinator or the nurse currently in charge of the department." However, the policy lacked a process or procedure for ensuring it is updated to reflect actual staff working each shift.	F 356	2.Actions taken to identify other potential residents having similar occurrences: All residents had potential to be affected by this deficient practice. 3.Measures put in place to ensure deficient practice does not recur: Education was provided to staff addressing the components of this deficiency related to the posting of staffing hours, and policy for posting staffing hours will be reviewed and revised to include procedure for updating tool with staffing changes by 13 Dec 15. 4.Effective implementation of actions will be monitored by: The Director of Nursing, or their designee, will audit posting of staffing hours on a weekly basis for three months. The data collected will be presented to the Quality Assessment & Assurance Committee meeting, quarterly, and at that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 371	Continued From page 86	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure raw meat was stored in a safe manner to reduce the risk of cross contamination to other foods in 1 of 2 refrigerators observed in the main kitchen. This had potential to affect 15 of 15 residents who could have consumed the potentially affected foods that was under the raw product. Findings include: During the initial tour of the facility kitchen on 10/19/15, at 6:21 p.m. a Norlake Advantage refrigerator was opened and inspected. The fridge had 4 shelves, and sitting on the top shelf was a plastic container which contained a single, un-cooked chicken breast. The container was labeled, "CHX [chicken] BREAST - RAW - 10/17," and there were visible light pink colored juices on the bottom of the container. The shelves below the raw meat contained several other food items including a white tray which contained approximately ten non-sealed, bagged raw	F 371	F371-E Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure raw meat is stored in a safe manner to reduce cross contamination. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents:	12/29/15

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F 371	Continued From page 87 vegetables, and a plastic container without a lid of approximately five non-sealed, bagged servings of Spanish rice. During observation of meal preparation on 10/21/15, at 9:11 a.m. (two days later) the plastic container with raw chicken remained in the Norlake refrigerator on the top shelf. However, there was now an additional plastic container of raw turkey burger patties on the top shelf labeled, "T. Burgers 10/15 and 10/18". The plastic tray of non-sealed, bagged vegetables and Spanish rice remained underneath of the containers of raw chicken and turkey burgers. During interview on 10/21/15, at 9:48 a.m. cook (CK)-A stated raw meats should not be stored on the top shelf because if the container leaks or spills, it would contaminate the other foods, and stated raw meat, "Should be on the bottom [shelf]." CK-A stated she received training when she was hired to work in the kitchen that, "Meat goes on [the] bottom shelf." During interview on 10/21/15, at 10:38 a.m. certified dietary manager (CDM) stated raw meats should be stored on the bottom of the refrigerator and, "Technically anything that's raw should be stored on the bottom." CDM stated if the containers of raw meats were to leak or be knocked over, it could cause spillage onto the other food below it in the refrigerator. During interview on 10/22/15, at 3:07 p.m. corporate registered dieticians (RD)-A and RD-B stated raw meat should be placed, "Ideally on a bottom shelf," because if it was knocked over or spilled it could contaminate the bagged vegetables and Spanish rice stored below it.	F 371	The Dietary Manager immediately moved the covered/sealed pan of raw chicken/turkey to the bottom shelf upon surveyor notification of finding on 21 Oct 15. This action was taken per surveyor's recommendation. 2.Actions taken to identify other potential residents having similar occurrences: All residents served out of the main kitchen had the potential to be affected by the issue cited in the statement of deficiencies. 3.Measures put in place to ensure deficient practice does not recur: Refrigerator and Freezer Storage policy was changed to reflect that all raw meats will be stored on bottom shelving 27 Oct 15. The Dietary Manager began educating the Dietary staff on the surveyor's recommendations to store all raw meats on the bottom shelving immediately. All Dietary employees were educated by 11 Nov 15. 4.Effective implementation of actions will be monitored by: The Dietary Manager, or designee, will audit the storage of raw meat in the refrigerators to insure safe practices are followed. Audits will be done weekly for one month and then quarterly for six months. 5.Those responsible to maintain compliance will be: The Dietary Manager is responsible for the overall compliance.	

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F 371	Continued From page 88 RD-A stated raw chicken and turkey could potentially contain bacteria and cause food borne illness if the juices were spilled onto other foods. The facility Refrigerator and Freezer Storage policy dated 11/10/14, identified, "Meats or other raw items are thawed in the bottom of the refrigerator so that melting liquids do not drop onto other foods ... All food items will be stored in a manner to prevent drippings from contaminating other items below."	F 371	Completion date for certification purposes only is: November 11, 2015	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon in a timely manner for 1 for 3 residents (R85) reviewed for dental hygiene and who needed new dentures. Findings include: R85's quarterly Minimum Data Set (MDS) dated 9/1/15, identified R85 had intact cognition.	F 412	F412-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the	12/29/15

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F 412	Continued From page 89 During observation on 10/20/15, at 10:10 a.m. R85 was seated in his room in a wheelchair. R85 had visible missing teeth on his lower palate, and his upper denture moved in his mouth while he spoke. R85 stated his dentures were getting, "Worn down", and were, "Not effective anymore." R85 stated at times he had trouble chewing food because of the loose fitting dentures, and would like to have them looked at by a dentist. R85's Patient Progress Notes dated 8/11/15, identified R85 had been seen by the dentist who visits the facility. The dentist identified, "Pt [patient] has full upper and lower partial. Lower partial denture is not anchored on any teeth as all remaining lower teeth are fractured off at the gumline ... Both full upper and lower partial have extreme occlusial wear, and pt it using adhesive on both for retention. Pt is interested in new upper only ..." The dentist identified a treatment plan of, "Will tx [treat] plan full upper and full lower dentures and if pt decides to proceed, we can refer to an oral surgeon for the extractions of remaining lower teeth [roots]." R85's facility progress notes dated 8/11/15, identified R85, "...was seen by In House Dental ... recommends that resident has all remaining lower roots extracted with an oral surgeon & [and] then have a new full upper and lower denture made ... will discuss these recommendations with resident and if he chooses will send him out to a consult to pursue..." No further notes were identified in R85's medical record as having the follow up completed for new dentures as requested by R85 and the dentist. During interview on 10/26/15, at 10:05 a.m.	F 412	administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure dental recommendations are acted upon in a timely manner. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident is alert and orientated. Resident signed consent form for facility dental vendor but then chose to go to outside dentist. Social Worker met with Resident 412 to review resident preference for dentures on 26 Oct 15, and an oral consult was completed on 3 Nov 15. Appointment is scheduled with the oral surgeon to proceed with the denture process. 2.Actions taken to identify other potential residents having similar occurrences: Medical records or designee reviewed dental visit log to ensure residents with pending dental needs have follow up plan in place. Modified Resident QIS Interview questionnaire was asked of residents to ensure dental needs are met according to resident preference. 3.Measures put in place to ensure deficient practice does not recur: Due to dental vendor not being able to meet resident needs within facility, facility was in transition to a new dental vendor	

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F 412	Continued From page 90 registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided.	F 412	during survey. Facility has implemented IDT stand up meetings starting 30 Dec 15 to monitor for potential dental concerns . MDS Coordinator for the facility will ask oral care questions with RAI reviews and contact social worker or designee if dental needs are required or requested. Staff education will be provided on oral care to be completed by 13 Dec 15. 4.Effective implementation of actions will be monitored by: Dental logs will be reviewed monthly by medical records or designee for one year to ensure timely dental follow up has been completed. Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		12/29/15

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F 428 SS=D	Continued From page 91 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist recommendations to establish pain medication parameters for use were acted upon for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, no pain, and required extensive assistance with his activities of daily livings (ADLs). The MDS identified R5 had diagnoses including chronic osteomyelitis [an infection of the bone or bone marrow] and a non-pressure related foot ulcer. R5's signed Physician Order Report dated 10/6/15, identified medication orders for pain including the following: "Acetaminophen [medication used to treat pain and inflammation] tablet; 650 mg [milligrams] ...	F 428	F428-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure that pharmacist recommendations to establish pain medication parameters for use are acted upon. To assure continued compliance, the following plan has been put into place;	

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F 428	Continued From page 92 DX: [diagnosis] pain ... Every 4 Hours - PRN [as needed]." "Tramadol [narcotic-like pain reliever] - Schedule IV [four] tablet; 50 mg; ... Every 6 Hours - PRN." The signed physician orders did not provide or identify any parameters or direction for when nursing staff should administer the Acetaminophen versus the Tramadol to help control R5's pain. R5's Consultant Pharmacy Drug Regimen Reviews directed the following, "Potential by [sic] insignificant problem," to be acted upon by facility staff: 8/3/15 - " [#5] Please check if there are parameters for using prn Acetaminophen vs [versus] Tramadol?" 9/2/15 - "Repeat MMR [medication regimen review] 8/3/15 #5 - if not addressed." 10/1/15 - "Repeat 8/3/15, MMR #5. Does not appear to be addressed." R5's medical record was reviewed and there was no evidence the consultant pharmacist's recommendations were acted upon as requested on 8/3/15, 9/2/15, and 10/1/15, to assist in clarifying the parameters for R5's pain medication regimen. During interview on 10/26/15, at 9:36 a.m. licensed practical nurse (LPN)-A stated she would provide either of the medications to R5 based on how much pain he would complain of, however, she stated established parameters would ensure staff were treating R5's pain consistently. LPN-A reviewed R5's EMAR (electronic medical administration record) and stated there were no	F 428	1. Regarding cited residents: The cited resident is alert and orientated, and was interviewed on 30 Oct 2015. Resident requested that he be allowed to continue to request Tylenol as needed for general discomfort and indicated he no longer wanted Tramadol. The pharmacist recommendation was reviewed and medical provider contacted to discontinue prn Tramadol on 30 Oct 2015 due to non-use. 2.Actions taken to identify other potential residents having similar occurrences: The pharmacy recommendations from the past quarter were reviewed by 29 Dec 2015 to ensure follow up on pharmacy recommendations. Issues noted during the review were corrected for compliance. 3.Measures put in place to ensure deficient practice does not recur: Pharmacy recommendations will be distributed by Director of Nursing to designated nurses for completion. Education was provided on this deficiency and Pharmacy Medication Regimen Reviews that was completed 13 Dec 2015 with licensed staff. Education on Medication Administration was completed by 13 Dec 2015 for licensed staff and TMAs. 4.Effective implementation of actions will be monitored by: Audits will be completed on 10 residents with pharmacy recommendations monthly to ensure timely follow up for three	

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F 428	Continued From page 93 established parameters for R5's as needed pain medications. During interview on 10/26/15, at 9:54 a.m. registered nurse (RN)-A stated the nursing staff reviews the pharmacists recommendations after each visit and updates the physician with the pharmacy recommendations. RN-A reviewed R5's medical record and stated the recommendation by the pharmacist to establish parameters for R5's as needed pain medications was not addressed, and stated the recommendations should have been followed up on, "That's an issue." During interview on 10/26/15, at 11:14 a.m. the consulting pharmacist (CP) stated he allows facilities a certain time period for staff to address his recommendations, however, the facility should have addressed the recommendations made on 8/3/15, 9/2/15, and 10/1/15, and stated, "It should be done." A facility policy on medication regimen review and management was requested, but none was provided.	F 428	months by the Director of Nursing, or their designee. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 2015	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		12/29/15

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F 441	Continued From page 94 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement infection control practices and procedures to prevent the spread of infection for 1 of 3 residents (R118) observed during a wound dressing change. Findings include: R118's undated Resident Admission Record	F 441	F441-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission	

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F 441	Continued From page 95 identified diagnoses including cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg with unspecified severity-non-healing, and pseudomonas in wound. R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and required limited assistance for most activities of daily living (ADLs). On 10/22/15, at 10:16 a.m. licensed practical nurse (LPN)-F was observed completing a dressing change to R118's open wound to the right lower leg. LPN-F gathered the necessary supplies, laid a clean towel directly on the floor beneath R118's right foot, while R118 remained seated in her wheelchair. No barrier was placed between the towel and the floor. After washing her hands and applying gloves, LPN-F removed the soiled stockinet (a stretchy fabric used for bandaging), removed the soiled dressing with use of a small scissors, and then removed the absorption pad over the open wound to R118's right lower leg. The dressing and absorption pad were discarded in the trash, but the stockinet and scissors were set aside, while LPN-F proceeded to use Simply Saline Wound Wash to soak and loosen a Silversorb (antimicrobial wound dressing) from R118's open wound. Dark brown debris and slough was observed to break free from the wound and drip onto the towel beneath R118's foot. LPN-F removed the dark brown debris away from the wound using the saline wash to break it up and removed it. The saline wash, mixed with debris/ slough, was dripping from R118's right lower leg, onto the towel. The towel was visibly soaked through, in a circular area beneath R118's right heel, approximately six inches in diameter. At 10:27 a.m., LPN-F	F 441	against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Nurse completing the wound care is no longer employed by facility. 2.Actions taken to identify other potential residents having similar occurrences: Residents requiring dressing changes for wound care have the potential to be affected by area cited. 3.Measures put in place to ensure deficient practice does not recur: Education on Infection Prevention and revisions completed with licensed staff by 13 Dec 15. Education content used upon facility orientation and with annual in-services related to Infection Prevention reviewed and revised by 29 Dec 15. 4.Effective implementation of actions will be monitored by: Monitor a random sampling of residents with dressing change treatments five	

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	245513	A. BUILDING _____ B. WING _____	10/26/2015

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F 441	Continued From page 96 removed her gloves and washed her hands after cleansing the wound. At 10:29 a.m., LPN-F applied new dressings and a clean stockinet to the wound, then placed R118's foot back onto the footrest of her wheelchair. LPN-F folded the towel inward and draped it over the lined garbage bin. She picked up her supplies and stepped back behind R118, next to the night stand. LPN-F rested the scissors atop a Dycem mat, which covered the top of R118's night stand. No barrier was placed between the scissors and the Dycem mat. She then reached to open one of the night stand drawers. At this time, R118 self-propelled her wheelchair forward approximately 18 inches, so LPN-F could open the drawers and put away her supplies. The right front and back wheels of R118's wheelchair was observed to roll over the area of the floor that became soiled by the soaked towel. Once LPN-F had finished accessing the night stand drawers, R118 self-propelled her wheelchair back through the same area and returned to her original position. At 10:37 a.m., LPN-F retrieved a Clorox disinfectant wipe from her medication/treatment cart and wiped the flooring beneath where the towel was placed, then obtained another sanitizing wipe from her cart and returned to wipe the scissors clean and return it to one of the night stand drawers. LPN-F did not wipe the Dycem mat where she had rested the soiled scissors on R118's night stand. LPN-F stepped away from the area and the original (soiled) stockinet which had been set aside earlier, was draped over a thin metal bar of R118's wheelchair, located behind the right foot rest, near the right front wheel. The stockinet was observed with multiple, circular, light to dark brown spots of dried wound drainage.	F 441	times per month for three months. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Infection Control Coordinator for the facility will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 441	Continued From page 97	F 441		

During interview on 10/22/15, at 10:51 a.m. LPN-F stated it was her typical practice to use a towel directly on the floor to, "Sop up any fluids that drip to the floor," during R118's wound dressing changes. LPN-F stated she used a Clorox disinfectant wipe to clean the surface of the floor after the dressing change. LPN-F stated she did not realize R118 propelled her wheelchair through the soiled area of the floor before she disinfected it. LPN-F stated when she was cleaning up the supplies R118 removed the stockinet from the soiled linens she had gathered, and it was R118's preference to rinse out her stockinet and re-use them, rather than send them through the laundry. When LPN-F was asked about placing the soiled scissors on top of the Dycem mat on R118's night stand, she stated, "[I] had to put it somewhere..." LPN-F stated she typically tried to keep the scissors apart from her clean dressings and to keep it off of the floor, and LPN-F stated she thought she had wiped the area where she had set the scissors with a sanitizing wipe.

During interview on 10/26/15, at 2:24 p.m. registered nurse (RN)-B, the facility's infection control coordinator, stated disinfectant and sanitizing wipes should have been amongst the supplies LPN-F gathered for R118's dressing change. RN-B stated without a proper barrier beneath the towel, LPN-F should have disinfected the flooring immediately, and if the wheelchair did come in contact with the soiled area, it should have been sanitized immediately. RN-B also stated a barrier should have been placed between the soiled scissors and R118's night stand, and the soiled stockinet should have been sent to the laundry and replaced with a clean one. RN-B stated if the material was obviously soiled it

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F 441	Continued From page 98 needed to go to the laundry for cleaning. The facility's Infection Control Committee- Duties and Responsibilities policy dated 6/14, directed the facility's committee was responsible for developing training programs for all facility personnel on infection control policies and procedures. The committee was also responsible for ensuring the facility maintained a sanitary environment, with all personnel following established infection control procedures and precautions. The facility's training program was to include the use of protective barrier equipment, along with the decontamination and disposal of equipment when exposed to blood/ bodily fluids.	F 441		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration effectively assessed and developed a plan to address the inadequate staffing in the facility as identified during the recertification survey. This had potential to affect all 48 residents residing in the facility. Findings include: > Refer to F353; The facility failed to provide	F 490	F490-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents	12/29/15

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F 490	Continued From page 99 adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed, nor have the administration revised delegations or staff	F 490	or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15. Facility has developed and implemented action plans for cited deficiencies related to the care and services of residents (Refer to F353). Quality Assessment and Assurance Committee will meet in January to review and revise action plans. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected. 3.Measures put in place to ensure deficient practice does not recur: Facility has added a QAPI meeting to be conducted between the quarterly Quality Assessment and Assurance Committee meetings. Action plans will be developed as needed for indicated quality needs as identified at QAPI. Quality Assessment and Assurance Committee will determine	

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F 490	Continued From page 100 responsibility. During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time." During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing and the cares are not able to be completed. NA-T stated the administration held a meeting a few months ago with all staff and talked about solutions to short staffing, however, nothing had been done to improve the lack of staff to ensure resident cares can be completed, and administration had not followed up regarding what is being done to meet the needs of the residnets. During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The	F 490	compliance regarding action plan areas. IDT was educated on QIS Quality Assessment and Assurance Committee and Staff was educated on the role of Quality Assessment and Assurance Committee by 13 Dec 2015. 4.Effective implementation of actions will be monitored by: Administrator and Quality Assurance and Assessment Committee will monitor action plans and report to corporate for assistance in oversight. Action plans will be monitored for progress towards goals and revised as needed. Quality Assurance and Assessment Committee will determine compliance regarding action plan areas. Administrator will give updates on action plan implementation at Resident Council and staff meetings times for three months. Elim COO, or designee, will monitor Administrators performance monthly for three months to ensure administration has been acting on these concerns identified by staff and residents. 5.Those responsible to maintain compliance will be: Corporate COO or designee is responsible for compliance.	

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F 490	Continued From page 101	F 490		

administration had done nothing to help with cares, but they expect the floor staff to get the work done and only come onto the floor when you guys [state surveyors] are here."

During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was not being completed as assessed. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked the resigning floor staff's input on how to handle the short staffing situation.

During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in extra staff to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed becasue there was not enough staff to provide the cares, and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed, although DON was aware there was not enough staff to provide the bathing. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done this week, "Because you guys [state surveyors] are here."

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F 490	Continued From page 102 During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix the lack of staffing, and SM-B had heard nothing further on how administration will resolve this. During interview on 10/26/15, at 5:06 p.m. the DON stated, "Right now we are just stuck on the staffing [lack of]. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing, however, the concern of lack of staff is ongoing. The DON stated facility management had offered hiring bonuses, implemented significant differential pay, and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of summer, when students returned to college, as well as eight facility staff who left on maternity leave. The DON confirmed the facility was still accepting new admissions, and stated she was aware of staff concerns of residents who were not receiving baths or oral cares, and, "This is one of the things that is tied to staffing. We are supposed to have a bath aide [but] have not had	F 490		

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F 490	Continued From page 103 one since September, I think everybody [residents] is getting really good wash ups." When interviewed on 10/26/15, at 4:24 p.m. the administrator stated staff had voiced concerns to him regarding the lack of staffing and, "They [staff] need more people", to help complete resident cares. The facility staffing was determined based on the size of the building, and if they currently had many residents who required extensive staff assistance for cares. The facility did cut hours if they are down in resident census, and use a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals x amount of dollars." The administrator stated he had "certainly identified there is a problem" with lack of staffing, and the focus was to hire and recruit new staff stating it had been the focus, "For a long time." Further, the administrator stated the facility had "used everything" to recruit more staff, and he felt there was "no stone unturned" in trying to address the issue of the lack of staffing to provide the necessary cares for the residents.	F 490		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		12/29/15

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F 520	Continued From page 104 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility's quality assessment and assurance (QA&A) committee failed to develop and implement action plans to address identified, systematic concerns of inadequate staffing patterns to ensure residents were provided with care and services in accordance with their assessed needs, for 13 of 42 residents (R126, R73, R27, R19, R45, R35. R21, R5, R64, R55, R85, R118 and R123) reviewed for compliance with quality of care and quality of life regulations. This had the potential to affect all 48 residents in the facility. Findings include: > Refer to F242; The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. > Refer to F244; The facility failed to ensure prompt responses to grievances related to	F 520	F520-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to have a Quality Assessment and Assurance Committee that develops and implements appropriate plans of action to correct identified quality deficiencies.	

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F 520	Continued From page 105 staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. > Refer to F282; The facility failed to provide appropriate incontinence products when necessary and failed to ensure appropriate use of a pressure relieving wheelchair cushion, as directed by the written plan of care, for 1 of 4 residents (R126) reviewed for pressure ulcers. The facility also failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. > Refer to F312; The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. > Refer to F353; The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A,	F 520	To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15. Facility has developed and implemented action plans for cited deficiencies related to the care and services of residents. Quality Assessment and Assurance Committee will meet in January to review and revise action plans. Cited residents will be invited to the Resident Council meeting on December 8th to review Staffing action plan. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected. 3.Measures put in place to ensure deficient practice does not recur: Action plans will be developed as needed for indicated quality needs as identified at Quality Assessment and Assurance Committee. Quality Assessment and Assurance Committee will determine compliance regarding action plan areas. IDT was educated on QIS QA&A by 13 Dec 2015. Staff was educated on the role of Quality Assessment and Assurance Committee by 13 Dec 2015. 4.Effective implementation of actions will be monitored by: Action plans will be monitored for progress towards goals and revised as needed. Quality Assurance and	

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	245513	A. BUILDING _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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F 520	Continued From page 106 OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. On 10/26/15, at 5:06 p.m. the director of nursing (DON) was interviewed regarding the facility's QA&A committee. The DON reported the QA&A committee gathered data from numerous sources in effort to identify potential quality deficiencies within the facility. Some of those sources included care conference reports, facility concern forms, verbal and/or written reports from staff/ family/ residents, resident satisfaction surveys and the on-going review of audit results, from past survey results or other quality deficiencies the committee had identified. The DON reported that all residents and/or their representatives were asked at each care conference whether the facility was meeting their needs and whether they felt they had been treated well. Any identified concerns were presented to the QA&A committee. When asked to provide an example of a quality deficiency the committee had identified, providing a description of any resulting action plans, the DON reported, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "I don't know how to make that a QA thing... We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed the QA&A committee was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. She	F 520	Assessment Committee will meet quarterly to determine compliance regarding action plan areas. Administrator will monitor Quality Assurance and Assessment Committee action plan. 5.Those responsible to maintain compliance will be: Administrator is responsible for compliance.	

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F 520	Continued From page 107 stated, the facility's QA&A committee had not actually developed or implemented an action plan to address the staffing concerns within the facility. However, she stated, "We report to QA what we have done." The DON stated facility management had offered hiring bonuses, implemented significant differential pay and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of Summer, when students returned to college. She added, there were eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident discharged. When asked whether the facility's QA&A committee had identified or addressed concerns of residents who were not receiving baths or oral cares, she responded, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." A facility policy regarding the responsibilities of the QA&A committee was requested, but was not provided.	F 520		

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 19th, 20th, 21st, 22nd, 23rd and 26th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, a complaint investigation was completed for H5513019 and substantiated. 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,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration effectively assessed and developed a plan to address the inadequate staffing in the facility as identified during the recertification survey. This had potential to affect all 48 residents residing in the facility. Findings include: Refer to F353; The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing	2 130	Corrected.	12/29/15

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2 130	Continued From page 3 choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed, nor have the administration revised delegations or staff responsibility. During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff	2 130		

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2 130	Continued From page 4	2 130		

had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time."

During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing and the cares are not able to be completed. NA-T stated the administration held a meeting a few months ago with all staff and talked about solutions to short staffing, however, nothing had been done to improve the lack of staff to ensure resident cares can be completed, and administration had not followed up regarding what is being done to meet the needs of the residnets.

During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but they expect the floor staff to get the work done and only come onto the floor when you guys [state surveyors] are here."

During interview on 10/23/15, at 11:52 a.m.

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2 130	Continued From page 5 registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was not being completed as assessed. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked the resigning floor staff's input on how to handle the short staffing situation. During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in extra staff to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed becasue there was not enough staff to provide the cares, and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed, although DON was aware there was not enough staff to provide the bathing. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done this week, "Because you guys [state surveyors] are here." During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting,	2 130		

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2 130	Continued From page 6	2 130		

baths, and grooming because of the lack of staff, however, nothing had been done to fix the lack of staffing, and SM-B had heard nothing further on how administration will resolve this.

On 10/26/15, at 5:06 p.m. DON stated, "Right now we are just stuck on the staffing [lack of]. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing, however, the concern of lack of staff is ongoing. The DON stated facility management had offered hiring bonuses, implemented significant differential pay, and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of summer, when students returned to college, as well as eight facility staff who left on maternity leave. The DON confirmed the facility was still accepting new admissions, and stated she was aware of staff concerns of residents who were not receiving baths or oral cares, and, "This is one of the things that is tied to staffing. We are supposed to have a bath aide [but] have not had one since September, I think everybody [residents] is getting really good wash ups."

When interviewed on 10/26/15, at 4:24 p.m. the administrator stated the staffing was determined based on the size of the building, and if they currently had many residents who required extensive staff assistance for cares. The facility

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2 130	Continued From page 7 did cut hours if they are down in resident census, and use a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals x amount of dollars." The administrator stated he had "certainly identified there is a problem" with lack of staffing, and the focus was to hire and recruit new staff stating it had been the focus, "For a long time." Further, the administrator stated the facility had "used everything" to recruit more staff, and he felt there was "no stone unturned" in trying to address the issue of the lack of staffing to provide the necessary cares for the residents. SUGGESTED METHOD OF CORRECTION: The facility administrator and/or their designee, could review and/or revise facility policies and procedures related to effective management and administration. Responsible personnel could be re-educated on these policies and procedures. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 130		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement	2 255		12/29/15

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2 255	Continued From page 8 appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility's quality assessment and assurance (QA&A) committee failed to develop and implement action plans to address identified, systematic concerns of inadequate staffing patterns to ensure residents were provided with care and services in accordance with their assessed needs, for 13 of 42 residents (R126, R73, R27, R19, R45, R35. R21, R5, R64, R55, R85, R118 and R123) reviewed for compliance with quality of care and quality of life regulations. This had the potential to affect all 48 residents in the facility. Findings include: *Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. *Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. *Refer to F282: The facility failed to provide appropriate incontinence products when necessary and failed to ensure appropriate use of a pressure relieving wheelchair cushion, as directed by the written plan of care, for 1 of 4 residents (R126) reviewed for pressure ulcers.	2 255	Corrected.	

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2 255	Continued From page 9 The facility also failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. *Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. *Refer to F353: The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. On 10/26/15, at 5:06 p.m. the director of nursing (DON) was interviewed regarding the facility's QA&A committee. The DON reported the QA&A committee gathered data from numerous sources in effort to identify potential quality deficiencies within the facility. Some of those sources	2 255		

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2 255	Continued From page 10	2 255		

included care conference reports, facility concern forms, verbal and/or written reports from staff/ family/ residents, resident satisfaction surveys and the on-going review of audit results, from past survey results or other quality deficiencies the committee had identified. The DON reported that all residents and/or their representatives were asked at each care conference whether the facility was meeting their needs and whether they felt they had been treated well. Any identified concerns were presented to the QA&A committee. When asked to provide an example of a quality deficiency the committee had identified, providing a description of any resulting action plans, the DON reported, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "I don't know how to make that a QA thing... We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed the QA&A committee was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. She stated, the facility's QA&A committee had not actually developed or implemented an action plan to address the staffing concerns within the facility. However, she stated, "We report to QA what we have done." The DON stated facility management had offered hiring bonuses, implemented significant differential pay and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of Summer, when students returned to college. She added, there were eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new

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2 255	Continued From page 11 admissions, but stated they had delayed some admissions until later in the week when another resident discharged. When asked whether the facility's QA&A committee had identified or addressed concerns of residents who were not receiving baths or oral cares, she responded, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." A facility policy regarding the responsibilities of the QA&A committee was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The medical director, facility administrator and/or director of nursing could review and/or revise facility policies and procedures related to the responsibilities of the Quality Assessment & Assurance committee. Responsible personnel could be re-educated on these policies and procedures. Identified quality deficiencies could be prioritized and evaluated for action plans. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 255		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of	2 265		12/29/15

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2 265	Continued From page 12 nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily.	2 265	Corrected.	

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2 265	Continued From page 13 Lake Ridge Care Center signed Physician Order Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. An Allina Health office visit note dated 4/20/15, indicated under "Your Plan" back on lantus 37 units at bedtime. R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in morning with a start date of 4/17/15 and Lantus at HS (at bed time), with a start date of 4/20/15. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15 to 4/26/15. The Buffalo Clinic Telephone order report dated 4/8/15, indicated at 8:58 a.m. received call from Lake Ridge care center, had blood sugar of 67 today, and told per orders to call if below 80. Per the Buffalo Clinic Telephone order report dated 4/27/15, Dr. Anderson indicated at 5:34 p.m., "Discussed with (staff) by phone. As of 4/20/15 visit, had written to return to Lantus 37 units at bedtime when it should have been once daily MORNING DOSE> Clarified with (staff) patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." Dr. Anderson then ordered Lantus 37 units once daily in the morning as prior to hospital stay. Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45 blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood glucose.	2 265		

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2 265	Continued From page 14 Resident Progress Note dated 4/25/15, indicated a blood sugar was only 51 while R45 was eating her breakfast meal. Review of the medical record did not indicate the physician was notified of the low blood sugar. Resident Progress Note dated 4/26/15, at 3:30 a.m. blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated "Resident had low BS (blood sugar) this morning was sweating and shaky. she had a BS of 38. The physician was called at 8:44 a.m." Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated "Resident had been receiving Lantus 37 units BID (twice a day) since 4/20, miscommunication written upon return from appointment. Spoke with Dr. Anderson and the HS dose has been d/c'd (discontinued) and will continue the 37 units in AM." During interview 10/26/15, at 9:30 a.m. with the DON who stated she was not aware of the insulin discrepancy and stated she was unable to locate a medication error. The DON further stated the nurses should have called the physician when they noted the order for Lantus to be given at HS since she was not on that before and because of her low blood sugars. Although R45 had an order to notify the physician if blood sugars were below 80, the facility did not notify the physician of the three low blood sugars. The facility's Change in Resident's Condition Or Status policy dated 7/14, directed "POLICY: It is	2 265		

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2 265	Continued From page 15 the policy of Elim Care, Inc. to promptly notify the resident, his or her Attending Physician, and representatives of changes in the resident's medical/mental condition and/or status." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to physician notification. Responsible personnel could be re-educated on these policies and procedures. Appropriate notices could be made to the physician's of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate physician notifications. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 265		
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 provide oral cares as	2 565	Corrected.	12/29/15

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2 565	Continued From page 16 directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance with personal hygiene, including brushing his teeth. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room, and showed he had several missing teeth on his upper palate when asked about his oral health. R5's care plan dated 7/14/15, identified R5 had an, "Alteration in ADLs [activities of daily living] of dressing, grooming and bathing...". Further, the care plan directed staff to assist R5 with, "Oral care am [morning] and pm [evening]..." During interview on 10/23/15, at 12:55 p.m. NA-F stated the care plan is used to know "what we're [staff] supposed to do" for the residents care. NA-F helped R5 get ready for the day, but did not offer or assist him to complete oral cares. Further, NA-F stated she should make sure R5 is having his teeth brushed and cleaned so R5 doesn't develop oral disease, or loose additional teeth. When interviewed on 10/23/15, at 1:04 p.m. RN-A stated R5 needs to be set up with assistance to complete oral cares, and NA-F should have offered his oral cares, "That's what should be happening." A facility policy regarding care plan implementation was requested, but was not provided.	2 565		

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2 565	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to implementation of resident care plans. Responsible personnel could be re-educated on these policies and procedures. Care and services for the individual(s) identified in the deficiency could be monitored for compliance with their written plan of care. Other residents could be evaluated for care plan implementation. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 2 residents (R126)	2 800	Corrected.	12/29/15

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2 800	Continued From page 18 reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents who currently resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: *Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. *Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. *Refer to F282: The facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. *Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5,	2 800		

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2 800	Continued From page 19 R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. RESIDENT CONCERNS ABOUT STAFFING: R126's admission Minimum Data Set (MDS) dated 9/29/15, identified R126 had intact cognition, and required extensive assistance to complete ADLs. During interview on 10/22/15, at 3:22 p.m. R126 stated he had to wait up to thirty minutes to have his call light answered to receive assistance with cares. R126 stated he needed staff assistance to use the restroom and get into his wheelchair, and he never knew how long it would take staff to answer his call light and that made him feel, "Anxious," and "Helpless." During a follow-up interview on 10/26/15, at 10:00 a.m. R126 stated his preference was to use a commode for toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He stated, he need help to get on and off the commode, but is unable to get onto the commode alone, and has to wait for staff to help. R126 reported he would have much rather used a commode for toileting and not a bed pan, because he doesn't get as "messy," But staff does not respond to his call light for assistance timely to help onto the commode, so he has to use the bedpan and not the commode, which he prefers to use. R55's quarterly MDS dated 9/15/15, identified R55 had moderate cognitive impairment, and required limited assistance from staff for ADLs.	2 800		

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2 800	Continued From page 20 During interview on 10/20/15, at 9:13 a.m. R55 stated she often had to wait for extend periods of time to get help to the bathroom, and was frequently incontinent because of waiting for so long. R55 stated the facility needed more staff to help residents with their cares, "They just don't have the people to work." R85's quarterly MDS dated 9/1/15, identified R85 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:03 a.m. R85 stated the facility had been, "Short of staff," for the past two or three months. R85 stated staff takes, "Quite awhile" to answer his call light to provide assistance with cares, and it had, "Been a big annoyance." R118's admission MDS dated 8/24/15, identified R118 had intact cognition, and required limited assistance from staff to complete ADLs. During interview on 10/21/15, at 11:34 a.m. R118 stated staffing seems worst on the weekend and in the evenings. R118 had a dressing change that needed to be completed, however, the resident had to wait over 6 hours for staff to complete this which caused the dressing to become saturated and drip fluids. R5's quarterly MDS dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 9:11 a.m. R5	2 800		

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2 800	Continued From page 21 stated the facility did not have enough staff, and staff would often complain about being short staffed to him, and at times R5 had stated there was only one nurse working for an entire shift. R5 stated his call light will take, "Fifteen to twenty minutes," to get answered, and was once left on the commode for, "An hour and a half," before staff came to provide assistance. R73's admission MDS dated 10/1/15, identified R73 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/21/15, at 10:55 a.m. R73 stated he had waited for nearly two hours in the past for staff assistance to go to bed and for his call light to be answered. R73 stated the staff are over worked and under staffed for the residents to be provided the necessary cares in the facility. R35's quarterly MDS dated 10/6/15, identified R35 had moderate cognitive impairment, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:29 a.m. R35 stated the facility staff worked short nearly all of the time, and there had been times R35 would have to wait to use the bathroom but was incontinent due to not receiving timely assistance from staff to get to the restroom. R123's admission MDS dated 10/15/15, identified R123 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 12:20 p.m. R123	2 800		

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2 800	Continued From page 22 stated she had waited for over an hour to get help to the restroom, causing her to, "Just use my diaper," which she stated made her, "Feel degraded." R27's quarterly MDS dated 9/22/15, identified R27 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:24 a.m. R27 stated she had waited for over an hour to have her call light answered to receive assistance, and the facility needed to have more staff to provide the cares the residents needed. FAMILY COMPLAINT'S ABOUT STAFFING: During interview on 10/21/15, at 11:31 a.m. family member (FM)-G stated they had visited their family member in the past and used the call light requesting staff assistance and "Waited, and waited, and waited," over twenty five minutes for staff to respond. There had been multiple occurrences of waiting for the call light to be answered, and FM-G stated, "It [long call light response times] concerns me." FM-G stated they had been told the owners of the facility felt they were "Adequately staffed," but stated she disagreed and the facility needed to add more staff to help residents with cares. During interview on 10/26/15, at 10:01 a.m. FM-H stated he had noticed oral cares were frequently not being completed because of the lack of staff at the facility. The call light had taken over one hour to be answered in the past, and was especially worse on the weekends.	2 800		

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2 800	Continued From page 23 STAFF CONCERNS ABOUT STAFFING: During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed. During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time." During interview on 10/22/15, at 1:23 p.m. NA-I stated the staffing at the facility was, "Not good," and there was frequently only one or two NA's on each hallway to provide cares to the residents. The residents frequently had to wait, and call lights were not answered timely because of the lack of staffing, "They [residents] don't get the care they should get." NA-I stated several staff	2 800		

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2 800	Continued From page 24 members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves. During interview on 10/22/15, at 1:36 p.m. NA-C stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff. During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing. NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed. During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but "they expect" the floor staff to get the	2 800		

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2 800	Continued From page 25 work done and only come onto the floor, "When you guys [state surveyors] are here." During interview on 10/22/15, at 2:53 p.m. licensed practical nurse (LPN)-F stated staffing is "Not adequate," to care for the residents and their needs, and she was quitting her position at the facility because she valued her nursing license, and felt it was being put in jeopardy because of the lack of staffing and poor care being delivered as a result. During interview on 10/23/15, at 7:07 a.m. LPN-B stated she felt the facility did not have enough staff to provide the necessary care to residents, and residents had to wait to get up for the day, and families voice frustration to the staff regarding the suffering care as a result of the poor staffing. LPN-B stated she recalled some dressing changes weren't completed because the nurse did not have time because they were busy trying to help provide the necessary care for the other residents. During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was suffering overall. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked for floor staff's input on how to handle the short staffing situation. During interview on 10/26/15, at 2:32 p.m. occupational therapist (OT)-K and occupational therapist assistance (OTA)-J stated the floor staff could use more help, and the biggest complaint they hear from residents was the lack of staffing	2 800		

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2 800	Continued From page 26	2 800		

and waiting, "Way too long for [call] lights," to be answered. OT-K and OTA-J stated they were not aware of any actions being taken by the facility to address the short staffing concerns.

During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in people to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done, "because you guys [state surveyors] are here."

During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix this.

The facility LRCC (Lake Ridge Care Center) documents, which displayed the names of the staff working on the floor for each shift, dated 10/19/15, to 10/23/15, were reviewed. The document identified each unit of the facility

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2 800	Continued From page 27 (Oasis, Lake View Lane, Mill Creek Bridge, and Northwoods), and provided blank spaces in which a staff members name was written to identify were they were scheduled to work. > On the AM shift, 10/19/15, the Oasis unit had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods each had open spaces identifying no staff were scheduled to work; and were left with just one nurse and one NA for each unit. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/20/15, the Oasis unit again had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods had open spaces with no staff names written in. Both units continued with just one nurse, and one NA working on the floor providing care for the residents. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/21/15, the Mill Creek Bridge had no NA displayed, only having a nurse assigned to provide care to the residents. Northwoods had one nurse and one NA to provide cares to the residents. The document identified seven of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/22/15, the Lake View Lane had no nurse identified, and only one NA. Mill Creek Bridge and Northwoods again each only had one nurse and one NA identified as providing cares. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/23/15, the Oasis unit had	2 800		

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2 800	Continued From page 28 no staff name identified as being assigned to work on the unit, and the Lake View Lane did not have a nurse identified. The document identified five of the thirteen spaces used to identify staff, to be blank. On 10/26/15, at 5:06 p.m. the director of nursing (DON) stated, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON stated the facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. DON stated the facility's staffing shortage began around the end of summer when students returned to college, and there were also eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident was discharged. When asked whether the facility had identified or addressed concerns of residents who were not receiving baths or oral cares, DON stated, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and	2 800		

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2 800	Continued From page 29 if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from residents, employees and families. Interventions could be identified and implemented to remedy the insufficiencies identified, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		12/29/15

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2 830	Continued From page 30 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce pain for 1 of 3 residents (R118) reviewed for pain. R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change. The facility also failed to provide proper wheelchair positioning for 1 of 1 residents (R57) who was leaning significantly to the right side. Findings include: PAIN R118's undated Resident Admission Record identified diagnoses including peripheral vascular disease (PVD), osteoarthritis in right hip, cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg non-healing with an infection, chronic pain syndrome, and Trigeminal Neuralgia (nerve pain). The admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact	2 830	Corrected.	

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2 830	Continued From page 31 and she required limited assistance for most activities of daily living (ADLs). The MDS identified R118 did not receive scheduled pain medication, but received as needed (PRN) pain medication and non-pharmacological interventions for pain management. The MDS identified the pain made it difficult to sleep at night, and limed her day to day activity. A self-reported numerical pain rating scale identified her current pain was a nine out of 10 (a zero (0) to 10, numeric pain rating scale of 0 = no pain, 10 = the most intense pain imaginable). Her pain was identified as frequent, but did not include a verbal description of the pain even though the MDS identified she had one arterial or venous ulcer at the time of the MDS. The Care Area Assessment (CAA) dated 8/24/15, identified R118 needed assistance with all ADLs due to weakness and decreased mobility from osteoarthritis, but wanted to do as much for herself as possible. The CAA identified R118 had a stasis ulcer on her right leg that was infected and continued to drain large amounts of fluid. The CAA identified R118, "Is complaining of pain due to neuropathy, osteoarthritis, and stasis ulcer on right lower leg. States that PRN Tramadol [Ultram, an analgesic medication] relieves pain. Also uses warm towels and repositioning. Staff will continue to monitor for pain and update MD [medical doctor] as needed." Although the MDS identified R118 had pain, which made it difficult to sleep, and limited her day to day activity, the facility had not assessed this area to determine if the pain regime was appropriate for R118. The care plan dated 10/9/15, identified R118 was at risk for uncontrolled pain related to osteoarthritis and stasis ulcer to her right lower	2 830		

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2 830	Continued From page 32 extremity. The care plan goal was for R118 to state her pain was decreased with the use of an analgesic, or show non-verbal signs of decreased pain. Interventions included the following: ·Encourage R118 to report pain levels PRN, per a numeric scale as able. ·Administer medications to R118, routine and PRN, as ordered for pain. ·Monitor R118 for changes in comfort PRN, reassessing her pain as needed. ·Offer R118 comfort measures PRN, of repositioning, heat, cold, massage, diversional activities, etc... During observation and interview on 10/21/15, at 11:30 a.m. R118 complained of unmanaged pain related to an open sore to her right, lower leg. She stated a routine dressing change had just been completed to her right leg and reported the pain she experienced during these dressing changes was excessive, stating her pain "hits over a 10." R118 stated if the nurses think of giving her pain medication before and after the dressing change they will, along with some ice. The ice packs, and pain medication at times, "Will subside almost, and then all of the sudden it is like a grabbing pain that almost sends me through the ceiling." During this conversation, R118 was frequently rubbing her right, lower leg and applying ice packs to the area. R118 stated her current pain level was,"down to a five [5] ... it is tolerable." R118 reported a pain rating of 5 was an acceptable level of pain for her. On 10/22/15, at 9:28 a.m. R118 was observed in her room, receiving her morning medications from licensed practical nurse (LPN)-F. Both LPN-F and R118 confirmed she had just received a pain medication (Gabapentin 300 mg, pain medication to treat nerve pain) and she typically	2 830		

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2 830	Continued From page 33 liked to wait "for her pain pill to kick in," before her dressing change was completed. R118 asked LPN-F to return in a half hour to complete her dressing change and to bring an ice pack. At 10:01 a.m., R118 stated, "[Her pain medication] never quite cuts it... when they start scraping, there's nothing [that could stop the pain]." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m. LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing	2 830		

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2 830	Continued From page 34	2 830		

change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, it's starting to burn." LPN-F asked R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated, "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118.

During interview on 10/22/15, at 10:51 a.m. LPN-F confirmed the verbal and non-verbal pain indicators she observed, which was a typical reaction during her dressing changes. LPN-F reported R118's doctor and nurse practitioner were aware of these symptoms. LPN-F stated R118's pain management regimen consisted of offering Ultram first, then oxycodone if the Ultram was not effective. LPN-F added, she could also have ice at any time and this has been the same pain management regimen for R118 for some

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2 830	Continued From page 35 time. She was not sure what the rational of the physician was, for not making further changes to the pain medicaiton regimen. LPN-F stated, She trys to give her (R118) time when she removed the dressing, so she (R118) can take a breath and "get her bearings" and will then continue when she is ready. R118's current physician orders dated 10/26/15, directed the following wound treatment and pain management regimen: ·Wound treatment to stasis ulceration on right lower extremity- cleanse wound, apply Silversorb, cover with ABD pad and Kerlix, change dressing daily and PRN. ·Gabapentin 300 milligrams (mg), twice daily for peripheral neuropathy/ polyneuropathy. ·Ultram 50 mg, every four hours PRN for pain, for chronic pain syndrome. ·Oxycodone 5 mg, every four hours PRN for pain not relieved by Ultram, for chronic pain syndrome. Review of R118's physician progress notes from 8/17/15, to 10/26/15, identified the following: R118's New Patient History and Physical Examination, completed by medical doctor (MD)-A and dated 9/3/15, noted she had osteoarthritis affecting her knees, shoulder and hip, with residual pain post knee and hip arthroplasties. The report did not further address her pain. On 8/24/15, nurse practitioner (NP)-A noted R118 had complaints of pain to her right lower extremity with dressing changes. On 9/10/15, NP-A noted the appearance of R118's right lower leg and reviewed the dressing treatments. NP-A noted, "Discussed pain control will add oxycodone for mod [moderate]/severe pain." On 9/23/15, a Wound Care/ Hyperbaric Medicine	2 830		

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2 830	Continued From page 36 History and Physical noted, "There is a wound on the anteromedial portion of [R118's] right lower leg. This measures 11 x [by] 12.5 x 0.1 cm [centimeters]. The wound is about 60% yellow fibrin and 40% pale red. It is very tender to touch and I am unable to do any sort of debridment on it. It does not appear to be infected... I initially tried to dress the patient's wound with Medihoney; however, the patient developed a lot of discomfort with this. My initial inclination had been to treat it with Iodosorb in an attempt to control drainage but the patient was afraid that that would be painful... She did receive a dose of oxycodone here and once her pain got better her wound was then dressed..." On 10/8/15, NP-A addressed R118's chronic right lower leg ulcer. NP-A noted, "Resident today says, 'I'm ok,' but frowning and awaiting R [right] LE [lower extremity] dressing [change]. C/o [Complains of] pain to R LE. Refuses to go back to Monticello Wound Clinic- 'They don't know nothing.' She is very particular about what she will allow to be put on R LE wound... looks unhappy- waiting for dressing [change]." The note directed no change to the wound treatment and to continue with antibiotic treatment for cellulitis through 10/12/15. On 10/19/15, NP-A noted R118's emergency room visit was reviewed. The note did not address R118's stasis ulcer. No further assessment, description, or plan for pain management were included in the physician progress notes. Review of R118's Electronic Medication Administration Record (EMAR) from 9/1/15, to 10/25/15, identified the following as PRN pain medications were administered for right, lower extremity and leg pain.	2 830		

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2 830	Continued From page 37 The September 2015 EMAR identified R118 took a total of 103 doses of PRN pain medication. She took 68 doses of Ultram 50mg, which were effective 42 of 68 opportunities; slightly effective 14 of 68; not effective 2 of 68, and other, which was not identified for 1 of 68 opportunities. R118 had 35 doses of PRN oxycodone 5mg in September 2015, which was effective 14 out of 35 opportunities; slightly effective 3 out of 35; and other which was not identified 3 out of 35, opportunities. The October 2015 EMAR identified R118 was administered 100 doses of pain medication for right, lower extremity leg pain. She took 49 doses of Ultram 50mg, which was effective 18 out of 49 opportunities; slightly effective 17 out of 49; and not effective 6 out of 49 opportunities. R118 had 51 doses of PRN oxycodone 5mg, in October 2015 which was effective 34 out of 51 opportunities; slightly effective 11 out of 51; not effective 5 out of 51 and other, which was not identified, 1 out of 51 opportunities. Review of the EMAR PRN administration times from September to October 2015, did not correlate with R118's dressing changes, because the dressing changes were not consistently documented. Even though R118 was administered 203 doses of PRN pain medication, taken in 55 days, approximately 3.7 doses of PRN pain medication each day, along with her scheduled Gabapentin 300 mg twice a day. R118 continued to experience significant pain with her dressing changes.	2 830		

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2 830	Continued From page 38 Review of R118's nursing progress notes from 8/17/15, through 10/26/15, identified complaints of pain for R118: On 8/24/15, at 10:18 p.m. LPN-G noted, "Changed dressing on lower right leg ... About an hour later Resident had c/o a 'burning pain.' Writer asked if a pain pill would help or if it was too much and it needed to be taken off? Resident asked for it to be taken off. Writer took off dressing... cleaned wound and only applied Bacitracin with non-stick dressing then covered with ABD and wrapped with Kerlix. Resident has not have any further c/o pain but is requesting that she receive something else on the wound that won't burn." On 8/27/15, at 1:09 a.m. LPN-D noted, "[R118] rates pain 8/10; ...per resident alginate dressing 'burns' refused to have on skin; ...communication being sent to update PMD [primary medical doctor]." On 8/27/15, at 10:23 a.m. LPN-F noted, "Leg dressing changed... Area continues to be red, macerated et [and] tender to the touch... Resident claims the wound spray hurts her when use for washing wound. Resident refused it to be used on her D/T [due to] reported pain." On 9/6/15, at 10:48 p.m. LPN-D noted, "[R118] c/o pain in RLE... dressing removed per [R118's] request; cool cloth applied with some relief; leg has been elevated; will reassess in one hour when may have prn pain medication." On 9/7/15, at 1:39 p.m. registered nurse (RN)-C noted, "[R118] refused to have dressing put on in fear that it would start hurting again... [R118] is leaving it open to air. PRN given." On 9/8/15, 2:28 p.m. LPN-B noted, "Writer called the on call MD/NP and left a message regarding resident's wound on her leg. Resident is refusing to let staff place a dressing on her leg per orders."	2 830		

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2 830	Continued From page 39 On 9/8/15, 11:10 p.m. LPN-C noted, "[R118] c/o pain to RLE. [R118] is unable to have any more prn pain medication for another 2 [two] hours. On call physician... said to use standing order of Tylenol. Will administer Tylenol and continue to monitor." On 9/13/15, at 12:25 p.m. LPN-B noted, "... [R118] does c/o pain during a.m. dressing change... PRN pain medication given x [times] 2 at this time." On 9/19/15, at 1:12 a.m. LPN- D noted, "[R118] c/o 7/10 pain right lower extremity; somewhat relieved with prn Tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]." On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, 'It burns so bad when drainage is left on my leg.'" On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds were given closer together. Resident has been seen by NP. Area on leg measures 16 cm x 10 cm draining et macerated with some greenish color at first change when NP was in room." On 10/12/15, 2:27 p.m. LPN-F noted, "[R118] continues to c/o pain. PRN pain meds given x 2. Resident makes requests for dressing changes. Leg continues to be painful et macerated during dressing changes." On 10/15/15, at 12:09 p.m. LPN-J noted, "Treatment completed to RLE... C/o pain while treatment is being completed, had received pain med prior to tx [treatment] being done. States that it hurts when it is open to air." On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication." During interview on 10/26/15, at 10:42 a.m.	2 830		

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2 830	Continued From page 40 nursing assistant (NA)-A stated, R118 has pain in her legs and she had seen her "pretty upset and crying." NA-A stated has seen R118 in pain and/or has complained of pain to her almost daily. NA-A stated she told the facility nurses when R118 complained of and/or appeared in pain, to see if she could be given any pain medication. NA-A stated the pain medications seemed "somewhat effective, [but] never 100% [effective]." During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's pain was mainly in her right lower leg, where she had an open area. RN-H stated the area has been improving, but was taking a long time. Upon review of the EMAR, RN-H reported R118's pain rating was typically around an 8 (0-10 pain scale) prior to receipt of her PRN pain medications. She reported R118's physician was at the facility every Thursday and was responsible for monitoring to ensure her pain management regimen was sufficiently effective. RN-H stated the most recent notation of the physician/ nurse practitioner commenting on her pain was the physician's progress notes, on 10/8/15. RN-H reported R118 had attended a wound clinic, but stopped going after 9/23/15, because she was very upset and did not want to go there anymore. RN-H stated she had spoken to R118 about her pain, as recently as 10/14/15, and she had indicated satisfaction with her pain management regimen. Upon inquiry as to R118's acceptable level of pain, RN-H replied she was unsure. RN-H stated that she was aware R118 had significant pain with dressing changes, but believed the current pain management regimen was effective for her. She stated the nature of R118's wound was going to result in some, inevitable pain during dressing changes. However, when told of the observed	2 830		

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2 830	Continued From page 41 dressing change on 10/22/15, RN-H denied knowledge of R118 having reactions to that extreme. RN-H stated, "If she [R118] is saying she is having that much pain, she is having that much pain." RN-H denied any reports of pain concerns for R118, from the facility nurses or NAs. RN-H stated, she expected staff would have updated the physician if/when they identified unmanaged pain, as the physician could have looked at getting an increase in R118's pain medication. RN-H stated R118's use of the ice pack was typical, however, "If that was what we were seeing, then that would not be a sufficient management of her pain." RN-H confirmed, R118's pain should have been reassessed. RN-H confirmed the facility used section J of the MDS as their sole pain assessment, which was only completed on a quarterly basis. During interview on 10/26/15, at 5:11 p.m. the director of nursing (DON) stated she gas completed R118's dressing changes on a frequent basis. She made sure R118 was medicated about one hour before the dressing change and asked her (R118) frequently throughout the dressing change, how she was doing. The DON stated she soaked the Silversorb in a significant amount of normal saline to keep it from sticking to her leg and made sure she had an ice pack to use for her leg at the time of dressing change. The DON stated she typically looked at R118 and tried to get her to laugh, distracting her during the dressing change. The DON stated she felt these interventions were "as effective as they can be." The DON stated, when R118 was first admitted to the facility, the dressing changes were much more painful than they were presently. The DON stated she had never seen R118 cry during a dressing change and upon discussion of the observed dressing	2 830		

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2 830	Continued From page 42	2 830		

change (10/22/2015), she denied having seen that kind of response from R118 any time she had completed or observed her dressing changes. The DON stated she expected some discomfort with this type of dressing change, but if R118 had demonstrated significant signs of pain as identified in the 10/22/15 observation, she expected the nurses to document this in the medical record and see what they could do about getting some different analgesic medications for her.

Although R118, had a stasis ulcer, had frequent progress notes that identified significant pain, and had nurses and nursing assistants who observed R118 in pain, either during her dressing changes or other times during the day. R118 only received Gabapentin 300 mg twice a day, for a routine scheduled pain medication, and Ultram 50 mg PRN for pain and oxycodone 5 mg PRN for moderate to severe pain. R118 only received the Gabapentin 300 mg prior to her dressing change in the morning of 10/22/2015, and then received oxycodone 5mg after the dressing change was completed. Even though R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change. The facility did not comprehensively assess and developed an appropriate pain management interventions to assist in reducing her pain.

The facility's Dressing Change, Clean policy dated 6/14, directed nursing to check physician orders to see if a resident required an analgesic prior to completion of dressing changes and to administer any analgesic medication as ordered. The policy did not further address pain management during dressing changes. Facility policies regarding pain management with dressing changes were requested, but no

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2 830	Continued From page 43 additional policies were provided. WHEEL CHAIR POSITIONING R57's quarterly MDS dated 9/22/15, identified R57 used a wheelchair for mobility, and required extensive assistance with activities of daily living (ADLs). R57's care area assessment dated 4/21/15, indicated she had contractures, and limited range of motion. R57's care plan dated 9/23/15, indicated alterations in mobility related to increasing weakness and directed staff to refer to physical and occupational therapy as needed. A Resident Progress Noted dated 9/13/15, indicated "pillow given to resident on wheel chair due to resident leaning to right." A Resident Progress Note dated 9/5/15, indicated R57 was up in wheel chair and would "drift off, leaning to right." During and observation on 10/19/15, at 8:16 p.m., R57 was sitting in a wheel chair. She appeared to be sleeping with her head resting on her right arm, leaning to her right. On 10/20/15 at 9:58 a.m., R57 was again observed sitting in her wheel chair, leaning to her right side. On 10/21/15, at 8:58 a.m., R57 was leaning to her right side in her wheel chair with her head resting on her tray table. On 10/23/15, at 3:55 p.m., R57 was observed sitting in her wheel chair, leaning to her right side with her head resting on a pillow that was placed on the right arm rest of her wheel chair. Although R57 continued to lean to the right, there were no supports noted in her wheelchair to support her trunk that prevented her from leaning. During and interview on 10/23/15, at 11:32 a.m., NA-B stated R57 refuses to lay down a lot of the	2 830		

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2 830	Continued From page 44 time, that's why we put pillow by her head. NA-B further stated R57 "has always leaned to the right side, not sure why that is." During an interview on 10/23/15, at 11:48 a.m., occupational therapy assistant (OTA)-J stated R57 was recently given a right lateral support for her wheel chair. OTA-J stated R57 was seen for a referral "about a month or so ago," but was not picked up for ongoing therapy. He felt R57's chair size was appropriate but that (R57) was more fatigued. During an interview on 10/26/15, at 1:53 p.m., NA-T stated, R57 is like that "all the time," they get her up for breakfast and then she falls asleep in her wheel chair. NA-T further stated, she used to lean a little but her leaning has been going on for the past few weeks. During an interview on 10/26/15, at 2:07 p.m., LPN-H stated, some they they have difficulty getting her (R57) to lay down. Sometimes they will place a pillow under her head to buffer the uncomfortable position but, "she always looks like that." LPN-H further stated, she though this was her second chair, and was unsure if (R57) had lateral supports or if they helped or not. R57 was at high risk for falling out of her chair because she is always leaning to her right. LPN-H further stated, R57 had been screened by occupational therapy for positioning, but was unsure if she had been re-evaluated. During an interview on 10/26/15, at 2:32 p.m., occupational therapist (OT)-K and OTA-J stated, they had received a referral in September for R57 because of her leaning and gave her a lateral supports. They also recommended she (R57) lie down if tired and listed the potential for several	2 830		

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2 830	Continued From page 45 negative outcomes of a sore back, and neck. At the time of the referral in September 2015, the lateral support was providing R57 with the amount of assistance she needed to sit up right and be able to propel herself in her wheel chair. OT-K and OTA-J further stated, R57 was "never leaning that bad when we saw her" and that her current positioning was a change and she should have been referred back to therapy for an evaluation. A policy addressing positioning for residents was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to pain management, proper positioning and coordination of care with outside providers. Responsible personnel could be re-educated on these policies and procedures. The individual(s) identified in the deficiency could be reassessed for the needs identified, with supporting documentation maintained. Other residents could be evaluated for appropriate pain management, proper positioning and coordination of care with outside service providers. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and	2 840		12/29/15

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2 840	Continued From page 46 proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 47 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bathing was completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. Findings include: LACK OF BATHING: R45's annual MDS dated 8/11/15, identified R45 had intact cognition, and required physical assistance from staff to complete her bathing. During interview on 10/22/15, at 1:46 p.m. R45 stated she does not always receive her schedule bath because of the facility being short staffed. Further, R45 stated not receiving her bath consistently makes her "angry", and she would like to have her bathing completed. Facility Lakeside Oasis Bath Records dated 9/14/15 to 10/21/15 were reviewed. The records were constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. R45's name was identified on the records, however for three weeks there were no staff initials identified next to her name to identify she received bathing. The spaces provided to record initials were left blank.	2 840	Corrected.	

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2 840	Continued From page 48 When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R45 enjoyed her showers, but added they were sometimes not completed due to a lack of staff to complete them. During interview on 10/23/15, at 11:59 a.m. RN-A stated she was not aware R45 was not receiving her baths as scheduled, but added it "wouldn't surprise me." Further, RN-A stated R45 should have been given her baths as scheduled. R19's quarterly MDS dated 9/29/15, identified R19 had intact cognition, and required assistance from at least two staff to complete her bathing. During interview on 10/22/15, at 2:11 p.m. R19 stated she was supposed to receive a bath twice a week, but had to go without her baths at times because there was "not hear enough" staff at the facility. Further, R19 stated she wanted to receive all of her scheduled baths as it was "very" important to her. A facility Mill Creek Bridge Weekly Bath and Vital List dated 8/3/15 to 10/21/15, identified R19 was scheduled for a bath twice a week. The listing was constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. However, R19 was not provided her baths for four of sixteen scheduled times according to the record. When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R19 enjoys her baths, but added some have been missed because there were no staff available to complete it.	2 840		

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2 840	Continued From page 49 During interview on 10/23/15, at 11:59 a.m. RN-A stated her expectation was for staff to complete bathing as required for residents. A facility policy on bathing was requested, but none was provided. LACK OF TIMELY PERICARE: R126's admission Minimum Data Set (MDS) dated 9/25/15, identified R126 had intact cognition, required extensive assistance for toileting and personal hygiene, and was continent of bowel. R126's care plan dated 10/12/15, identified R126 had an alteration in his elimination related to decreased mobility, but remained continent of bowel. Further, the care plan directed staff to complete, "Pericare with assist of 1 with am [morning] and HS [hour of sleep] cares." The care plan did not identify if or when pericare should be completed for toileting not associated with those set times. During interview on 10/20/15, at 3:22 p.m. R126 stated he was dependent on staff for help with pericare after having a bowel movement, however he did not always receive timely assistance with this. R126 used a bed pan, but stated his bottom would get sore if he sat on it for too long, so he would remove himself from the bed pan, and place newspaper underneath of himself to prevent the bed linens from becoming soiled while he waited for staff assistance with pericare's. When interviewed on 10/26/15, at 10:27 a.m. nursing assistant (NA)-A stated she had assisted	2 840		

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2 840	Continued From page 50 R126 with toileting and pericare's before, and noticed feces soiled newspaper on his bed before. NA-A stated she was unaware R126 was using it as a barrier to prevent the linens from becoming soiled while waiting for staff assistance. During interview on 10/26/15, at 2:18 p.m. registered nurse (RN)-H stated she was unaware R126 was using the newspaper after having a bowel movement while he waited for assistance with pericare's. A letter submitted post survey exit dated 10/28/15, authored by NA-T noted, "A couple of times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put himself on bedpan, notifying staff only when he was done." A letter submitted post survey exit, dated 10/30/15, authored by NA-D noted, "[R126] chose to use newspaper under himself even though I told him he didn't need to do that and we would change linen if it got soiled. He continued to put newspapers under him." A facility policy on toileting and pericare was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to the provision of assistance with activities of daily living (ADLs). Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of ADL services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other	2 840		

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2 840	Continued From page 51 residents could be evaluated for appropriate provision of ADL services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 840		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), who needed staff assistance with activities of daily living (ADLs. R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete her personal hygiene. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room. R5 had visibly long fingernails on both hands with a dark colored substance underneath several of the nails. R5 stated he was diabetic so "not	2 860	Corrected.	12/29/15

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2 860	Continued From page 52 everybody can cut them", but added his preference would be to have shorter nails. On 10/22/15, at 9:01 a.m. R5 continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. nursing assistant (NA)-T stated R5 seldom refused cares or assistance from staff, and nail care was to be completed on residents scheduled bath days. At 2:03 p.m. NA-T observed R5's nails and stated they were too long, and "not very clean underneath." Further, NA-T stated they were unaware of any preference of R5 to have long, dirty fingernails and they should be trimmed. During interview on 10/22/15, at 2:33 p.m. licensed practical nurse (LPN)-A observed R5's long, dirty fingernails and stated "they need to be cut." Further, LPN-A stated R5 was dependent on nursing staff for his nail care, and his nails should have been trimmed and cleaned on his bath day. When interviewed on 10/23/15, at 11:23 a.m. registered nurse (RN)-A stated R5 required assistance to complete his nail care, and his nails should have been cleaned and trimmed, "[They] should be taken care of when they get their bath done." R64's quarterly MDS dated 9/15/15, identified R64 had moderate cognitive impairment, and required extensive assistance from staff to complete his personal hygiene. During observation on 10/20/15, at 9:36 a.m. R64 was seated in a standard wheelchair in his room. R64 had visibly long fingernails with several nails having a dark colored substance underneath	2 860		

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2 860	Continued From page 53 several nails. R64 stated he preferred to have shorter kept nails adding they "could use a clip." On 10/22/15, at 9:04 a.m. R64 was seated in his wheelchair outside his room, and continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. NA-T stated R64 had never refused cares or staff assistance to their knowledge. At 2:03 p.m. NA-T observed R64's nails and stated they were "very long" and should be cleaned and trimmed. During interview on 10/22/15, at 2:33 p.m. LPN-A observed R64's nails and stated they should have been cleaned and trimmed on his bath day. When interview on 10/23/15, at 11:23 a.m. RN-A stated R64 had no desired preference to have long, dirty fingernails and they should have been cleaned and trimmed on his bath day. A facility policy on grooming and nail care was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to the provision of nail care. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of nail care services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate nail care. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.	2 860		

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2 860	Continued From page 54 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 860		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote urinary continence for 1 of 3 residents (R64) reviewed for urinary incontinence. Findings include: R64's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R64 had moderate cognitive impairment, required extensive assistance with toileting and was, "Always incontinent" of bladder.	2 910	Corrected.	12/29/15

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2 910	Continued From page 55 R64's Nursing Observations 3.0 Assessment dated 9/18/15, identified R64 to be "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." The assessment did not identify if any or what type of a toileting program needed to be implemented for R64, to decrease R64's incontinence. R64's care plan dated 9/21/15, identified R64 had an, "Alteration in elimination r/t [related to] weakness following hospitalization", but R64 was, "Aware of the need to void/defecate." Further, the care plan directed staff to, "Toilet per request", and, "Monitor for changes in elimination patterns and reassess quarterly and prn [per request or as needed]." During interview on 10/22/15, at 9:43 a.m. nursing assistant (NA)-T stated he helps R64 to the bathroom when he requests as care planned, but has noticed R64 to be "more incontinent of urine" lately. Further, NA-T was unaware of any set toileting schedule for R64. During observation of care on 10/23/15, at 7:24 a.m. R64 was assisted to the toilet by NA-F. NA-F removed a visibly soiled white incontinence pad from R64, and placed it in the trash stating R64, "Had the wrong kind of pad on." R64 should have had an "extra absorbent" green colored pad on during the night to help reduce irritation to his skin from being incontinent. NA-F stated R64's removed incontinence pad "was full" of urine, as R64 was typically incontinent in the morning, but when assisted to the toilet would sometimes void. Further, NA-F stated R64 was unable to verbalize when he needed to use the restroom, so she helped him "every two hours" to the restroom.	2 910		

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2 910	Continued From page 56 During interview on 10/23/15, at 11:34 a.m. registered nurse (RN)-A stated R64 was able to voice his need to use the restroom, "Most of the time", and should be helped with toileting every two hours. R64 should not be incontinence of urine, "More than a couple times a day," with his toileting ability, and the assessment completed on 9/18/15 should have identified a toileting program for R64 to promote continence. Although R64's assessment identified him as "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." There was no indication if R64 needed a scheduled toileting program, or was a check and change (no attempts to place on the toilet) even though R64 had been using the toilet, and NA-F stated he did have some continent voids. A facility policy on urinary incontinence was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who are incontinent of bladder to assure they are receiving the necessary treatment/services to assist with continence status. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for bladder incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser	21330		12/29/15

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21330	Continued From page 57 Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon in a timely manner for 1 for 3 residents (R85) reviewed for dental hygiene and who needed new dentures. Findings include: R85's quarterly Minimum Data Set (MDS) dated 9/1/15, identified R85 had intact cognition. During observation on 10/20/15, at 10:10 a.m. R85 was seated in his room in a wheelchair. R85 had visible missing teeth on his lower palate, and his upper denture moved in his mouth while he spoke. R85 stated his dentures were getting, "Worn down", and were, "Not effective anymore." R85 stated at times he had trouble chewing food	21330	Corrected.	

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21330	Continued From page 58	21330		

because of the loose fitting dentures, and would like to have them looked at by a dentist.

R85's Patient Progress Notes dated 8/11/15, identified R85 had been seen by the dentist who visits the facility. The dentist identified, "Pt [patient] has full upper and lower partial. Lower partial denture is not anchored on any teeth as all remaining lower teeth are fractured off at the gumline ... Both full upper and lower partial have extreme occlusial wear, and pt it using adhesive on both for retention. Pt is interested in new upper only ..." The dentist identified a treatment plan of, "Will tx [treat] plan full upper and full lower dentures and if pt decides to proceed, we can refer to an oral surgeon for the extractions of remaining lower teeth [roots]."

R85's facility progress notes dated 8/11/15, identified R85, "...was seen by In House Dental ... recommends that resident has all remaining lower roots extracted with an oral surgeon & [and] then have a new full upper and lower denture made ... will discuss these recommendations with resident and if he chooses will send him out to a consult to pursue..." No further notes were identified in R85's medical record as having the follow up completed for new dentures as requested by R85 and the dentist.

During interview on 10/26/15, at 10:05 a.m. registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85.

During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures

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21330	Continued From page 59 since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to dental services. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of dental services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate provision of dental services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21330		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		12/29/15

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21375	Continued From page 60 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement infection control practices and procedures to prevent the spread of infection for 1 of 3 residents (R118) observed during a wound dressing change. Findings include: R118's undated Resident Admission Record identified diagnoses including cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg with unspecified severity-non-healing, and pseudomonas in wound. R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and required limited assistance for most activities of daily living (ADLs). On 10/22/15, at 10:16 a.m. licensed practical nurse (LPN)-F was observed completing a dressing change to R118's open wound to the right lower leg. LPN-F gathered the necessary supplies, laid a clean towel directly on the floor beneath R118's right foot, while R118 remained seated in her wheelchair. No barrier was placed between the towel and the floor. After washing her hands and applying gloves, LPN-F removed the soiled stockinet (a stretchy fabric used for bandaging), removed the soiled dressing with use of a small scissors, and then removed the	21375	Corrected.	

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absorption pad over the open wound to R118's right lower leg. The dressing and absorption pad were discarded in the trash, but the stockinet and scissors were set aside, while LPN-F proceeded to use Simply Saline Wound Wash to soak and loosen a Silversorb (antimicrobial wound dressing) from R118's open wound. Dark brown debris and slough was observed to break free from the wound and drip onto the towel beneath R118's foot. LPN-F removed the dark brown debris away from the wound using the saline wash to break it up and removed it. The saline wash, mixed with debris/ slough, was dripping from R118's right lower leg, onto the towel. The towel was visibly soaked through, in a circular area beneath R118's right heel, approximately six inches in diameter. At 10:27 a.m., LPN-F removed her gloves and washed her hands after cleansing the wound. At 10:29 a.m., LPN-F applied new dressings and a clean stockinet to the wound, then placed R118's foot back onto the footrest of her wheelchair. LPN-F folded the towel inward and draped it over the lined garbage bin. She picked up her supplies and stepped back behind R118, next to the night stand. LPN-F rested the scissors atop a Dycem mat, which covered the top of R118's night stand. No barrier was placed between the scissors and the Dycem mat. She then reached to open one of the night stand drawers. At this time, R118 self-propelled her wheelchair forward approximately 18 inches, so LPN-F could open the drawers and put away her supplies. The right front and back wheels of R118's wheelchair was observed to roll over the area of the floor that became soiled by the soaked towel. Once LPN-F had finished accessing the night stand drawers, R118 self-propelled her wheelchair back through the same area and returned to her original position. At 10:37 a.m., LPN-F retrieved a Clorox

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21375	Continued From page 62 disinfectant wipe from her medication/treatment cart and wiped the flooring beneath where the towel was placed, then obtained another sanitizing wipe from her cart and returned to wipe the scissors clean and return it to one of the night stand drawers. LPN-F did not wipe the Dycem mat where she had rested the soiled scissors on R118's night stand. LPN-F stepped away from the area and the original (soiled) stockinet which had been set aside earlier, was draped over a thin metal bar of R118's wheelchair, located behind the right foot rest, near the right front wheel. The stockinet was observed with multiple, circular, light to dark brown spots of dried wound drainage. During interview on 10/22/15, at 10:51 a.m. LPN-F stated it was her typical practice to use a towel directly on the floor to, "Sop up any fluids that drip to the floor," during R118's wound dressing changes. LPN-F stated she used a Clorox disinfectant wipe to clean the surface of the floor after the dressing change. LPN-F stated she did not realize R118 propelled her wheelchair through the soiled area of the floor before she disinfected it. LPN-F stated when she was cleaning up the supplies R118 removed the stockinet from the soiled linens she had gathered, and it was R118's preference to rinse out her stockinet and re-use them, rather than send them through the laundry. When LPN-F was asked about placing the soiled scissors on top of the Dycem mat on R118's night stand, she stated, "[I] had to put it somewhere..." LPN-F stated she typically tried to keep the scissors apart from her clean dressings and to keep it off of the floor, and LPN-F stated she thought she had wiped the area where she had set the scissors with a sanitizing wipe.	21375		

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21375	Continued From page 63 During interview on 10/26/15, at 2:24 p.m. registered nurse (RN)-B, the facility's infection control coordinator, stated disinfectant and sanitizing wipes should have been amongst the supplies LPN-F gathered for R118's dressing change. RN-B stated without a proper barrier beneath the towel, LPN-F should have disinfected the flooring immediately, and if the wheelchair did come in contact with the soiled area, it should have been sanitized immediately. RN-B also stated a barrier should have been placed between the soiled scissors and R118's night stand, and the soiled stockinet should have been sent to the laundry and replaced with a clean one. RN-B stated if the material was obviously soiled it needed to go to the laundry for cleaning. The facility's Infection Control Committee- Duties and Responsibilities policy dated 6/14, directed the facility's committee was responsible for developing training programs for all facility personnel on infection control policies and procedures. The committee was also responsible for ensuring the facility maintained a sanitary environment, with all personnel following established infection control procedures and precautions. The facility's training program was to include the use of protective barrier equipment, along with the decontamination and disposal of equipment when exposed to blood/ bodily fluids. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to infection control practices during dressing changes. Responsible personnel could be re-educated on these policies and procedures. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to	21375		

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21375	Continued From page 64 ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure employees received a two-step tuberculin skin test (TST) for 5 of 8 new employees whose personnel records were reviewed. This had the potential to affect all 42 residents who resided in the facility.	21426	Corrected.	12/29/15

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21426	Continued From page 65 Findings include: Review of personnel files for a sample of new employees, identified nursing assistant (NA)-B was hired on 7/23/15. Although an initial TST was administered on 7/23/15, and read as negative with no induration on 7/25/15, a second step was not completed. Maintenance-A was hired on 8/26/15. Although an initial TST had been administered on 8/26/15, and read as negative with no induration on 8/28/15, no second step had been completed. NA-E was hired 9/10/15. Although an initial TST had been administered on 9/10/15 and read as negative with no induration on 9/13/15, no second step had been completed on entrance of the survey team. Dietary aide (DA)-A was hired on 9/10/15. Although and initial TST had been administered on 9/10/15, and read as negative with no induration on 9/12/15, no second step had been completed. Licensed practical nurse (LPN)-E was hired on 10/14/15. Although the first step TST had been administered on 10/14/15, the TST had not been read as of 10/22/15. During interview on 10/26/15, at 5:32 p.m. registered nurse (RN)-B stated she did the TSTs on the new employees and the second step was to be completed two to three weeks after the first step. The facility's Regulation for Tuberculosis Control in Minnesota Health Care Settings policy dated	21426		

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21426	Continued From page 66 7/13, directed testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single interferon gamma release assay (IGRA). SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to the required tuberculosis skin testing process. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medically related social services needs were identified and provided for 2 of 4 residents (R29 and R28) reviewed for social services. This resulted in actual, psychosocial harm for R28, who expressed fear, inability to sleep, and demonstrated signs of distress regarding	21475	Corrected.	12/29/15

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21475	Continued From page 67 concerns with her roommate (R29). Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/25/15, indicated the resident had severe cognitive impairment and had dementia with depression. R28's quarterly MDS dated 9/1/15, indicated the resident had severe cognitive impairment, and had dementia with depression. The MDS indicated R28 was depressed, had trouble sleeping, had little or no energy, felt bad about herself, and had trouble concentrating. R28's Care Area Assessment (CAA) dated 6/12/15, indicated the resident received Zoloft, an antidepressant, for diagnosis of depression. R28's care plan dated 9/11/15, indicated she was depressed and was to receive one to one visits to encourage expression of feelings and to, "Explore possible reasons for the resident's distress (e.g., environmental/psychosocial stressors, treatable medical conditions, etc); Implement a mood management plan to compliment drug therapy : sertraline (Zoloft)." The care plan indicated R28 had the potential for abuse from others related to cognitive loss, and the approach was for staff to discuss behavioral issues with the team members as needed, and evaluate the need for psychological referral and evaluation. R28's progress notes reviewed from 7/09/15, to 10/25/15, indicated the following incidents related to R29, who is R28's roommate: On 7/9/15, "Res. [resident] has been crying today. Res. is stating how when she was little her mom	21475		

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used to make her watch the baby and she didn't like it. Res. has also been say that her roommate asks so many questions and needs things and she is getting tired."

On 7/15/15, a note documented by activities indicated "Resident is having a hard time with her rooming situation. She says she is not getting much sleep because roommate is up a lot at night talking, delusional as to where she is and accusing resident of things. Resident is crying a lot and is in hopes of changing rooms. Writer consoled resident and said she would see what she could do about the situation."

On 8/24/15, resident and roommate had a dispute. R28 stated her roommate yelled at her and she became upset, was crying, and stated she was done dealing with her roommate and wanted a new room.

On 8/25/15, a progress note from social services indicated, "Spoke with res regarding incident with roommate last night, res did remember arguing with her roommate. She didn't say she wanted a different room today, but just said that she didn't want to talk to her roommate about just anything, only the weather. Writer validated her feelings letting resident know she doesn't have to talk to roommate about anything she didn't want to."

On 9/1/15, "Resident refusing to go into bed as roommate blocking roommate from entering. Resident when in room, 'peeks' into roommates side of room to make sure she is okay."

On 9/5/15, resident talked with writer and stated, "I'm loosing my mind, my roommate is rubbing off on me; up at 1 am. Talks of wanting a different room, did leave a message for SW [social

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worker], 1 on 1 with resident, and was effective at this time."

On 9/10/15, resident complaints of not sleeping well last night stating the lady in her room kept her up asking who she is and where she is.

On 9/10/15, progress note from social services indicated, "Writer was walking down the hall and res stopped writer and was upset because she stated 'I just saw on TV that I am being taken to court! I have nothing, this is not fair they stole all my money!' When writer asked who stole her money she was not able to say. Res roommate was then coming out of the room and res said 'oh that little bitch! She was screwing with him all night!' Writer let res know that was not nice to call some one names. Writer asked who him was and roommate got closer res said 'oh look here she is she just wants to screw' and she shook her fist at roommate. Writer directed ladies in opposite direction but it took some time for residents to go there separate ways. Res kept stating that 'this is my room' and 'she goes in there all the time and screws him, she is such a little bitch, I cant even eat- I don't even want to look at her."

On 9/12/15, resident found in roommates bed and she stated she does this to me all the time.

On 9/23/15, resident stated she was up all night with the lady in her room yelling all night. Resident stated she was, "Going crazy." One to one was given.

On 9/23/15, "Writer unplugged cord from computer res. stating 'I wish I had one of those' res was asked what? 'That cord for around my neck- I don't sleep cause of that lady in my room.' Res. stated 'I really wont do that but I never get

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any sleep with her in there.' 1 on 1 was given with relief. SS updated."

On 10/6/15, social service note indicated residents daughter called, "To talk to writer about concerns that resident called her about a man who was after her and her roommate, who was sleeping with all sorts of men and how resident just wanted to commit suicide. Assured Dtr [daughter] that no men were in the building and that res has talked about seeing the men before and they turn out to be not here and roommate does not have men in her bed at night to which [daughter] stated she figured and was not worried about it. She [daughter] was most worried about the suicide comment. [Daughter] is requesting a call from the MD [medical doctor] when he is here on Thursday and Writer let [daughter] know that she would talk to MD as well about res behaviors. Writer then spoke to res about suicidal behaviors and res has no plans to harm herself and is safe at facility. No further action needs to take place today."

On 10/07/15, "Res in confrontation with another Res in hallway this evening. Res was talking about going to 'See my lawyer this week to see what the weather is going to be.' She was also talking about how another res 'needs her ass kicked.' Res eventually calmed down and went into her room. Will continue to monitor."

A Lake Ridge Care Center Fax Update/Order form dated 10/8/15, indicated the MD attempted to call R28's daughter but had the wrong phone number and he would call the social worker tomorrow.

On 10/20/15, "Writer informed by NAR (nursing assistant registered) that Res claims roommate

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said she was going to cut her throat. Res called daughter to inform daughter of situation. Writer asked aides what happened. Aides said roommate didn't want to go in room because Res said she didn't want her there. Then Res made the claim that roommate said she'd cut her throat. Aides said roommate wasn't even around Res to make such a comment. Res and roommate separated at this time. Res on her way back to bed."

On 10/22/15, social service note indicated "Met with resident and discussed comments she made on 10/20/15. Res stated that she did not feel her roommate was going to slit her throat, res stated she felt safe and was not afraid of her roommate. She stated her roommate just wants the whole room that's all and she just gets that way sometimes. Asked res twice if she felt safe with her roommate during the conversation and both times res waved her hands at writer and said oh yes its fine."

On 10/23/15, social service note indicated resident came to writer upset with roommate because of all of her visitors and that she needed to get out of her room because her roommate gets mad at her and shuts the door on her. Because she was so upset writer asked if she felt like hurting herself and res stated, "No, I don't think so."

On 10/23/15, "Resident was up at the front door saying 'I am getting out of here.' Writer told resident, Oh it's raining out. You don't want to go out there. Resident replied, I don't care about the rain. I'm not staying here another night; live with these awful people here, I'm leaving. Resident was resistant at first but then writer got resident to go to the Vineyard. Writer reported this info to

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21475	Continued From page 72 social services and nursing. At this time nursing put a Wanderguard on resident." An Associated Clinic of Psychology visit note dated 8/17/15, indicated R28 had depression, and did not have suicidal ideation. The recommendations were to use validation techniques when she appeared to have concerns, or when she voiced concerns. A Geriatric Services Of Minnesota physician visit dated 9/10/15, indicated, "The patient [R28] did get a bit weepy today while complaining about conflicts with her roommate. I spoke with various staff and apparently the patient has had problems with at least a couple of other roommates and I think she maybe a candidate for a private room." The plan indicated to facility staff, "I will be happy to support a waiver request for a private room." There was no indication the physician recommendation regarding R28 receiving a private room was followed up on by the facility. During interview on 10/26/15, at 1:53 p.m. nursing assistant (NA)-T stated R28 and R29 started to have troubles being roommates a few months ago, because R29 gets, "Crazy" in the late afternoon and night time. R29 becomes more confused, and is up hollering during the night. NA-T stated they have come to work in the early morning and R28 would be awake and out of bed crying stating she is fearful of her roommate because R29 was, "Making her uncomfortable." R28 had expressed she, "Doesn't like being in that room," and continued to be "unsettled" about having to remain in the room with R29. R28 had ongoing episodes several times a week of not sleeping well at night because of R29, and NA-T stated these concerns	21475		

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21475	Continued From page 73	21475		

were reported to social worker (SW)-A, but SW-A stated she had spoken to R28's family and they didn't want the resident to change rooms, but rather just wanted the facility to add some pictures and music to try to enhance the physical space of the room for R28. NA-T stated one of R28's daughters had recently visited from out of town, and she had expressed desire for R28 to change rooms because she could, "See how it was," between R28 and R29; however, NA-T stated, "Nothing ever got done," about R28 and R29 rooming together.

During interview 10/26/15, at 4:08 p.m. NA-A stated R28 and R29, "Argue all the time, and [R29] is very forgetful; she cant remember five minutes to the next." She forgets what side of the room she is on and they both dig into each others things and it upsets both of them. "[R28] gets upset and will go on a rant that she has no one in her family; she has said she is better off dead but never told me she had a plan. She is not on any suicide checks. We are told there is not enough charting to separate them and the nurses do the charting. It would be nice if they could be separated."

During interview 10/26/15, at 4:13 p.m. licensed practical nurse (LPN)-A stated, "They [R28 and R29] fight a lot. I have asked for a room change and left messages with the social worker. I'm almost ready to give up; we keep charting and nothing gets done with it and the staff are very frustrated, they don't ask us about room changes and about what would work best, and who would be compatible with who. I suggested for her [R28] to move to room 126 when that was open because I felt her and the other roommate would be a good fit and they never moved her. [R28] tells me she wants to move.... [R28] says things

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that she wants to kill herself." LPN-A then stated, "I don't think things are charted as often as they occur." LPN-A stated R28 and R29 just, "Got into it with each other in the hall."

During interview 10/26/15, at 4:23 p.m. R28 stated, "I have never been treated like this ever in my life." R28 started to cry, and LPN-A (who was present at the time of interview) gave her a Kleenex. R28 stated, "I have asked for a different room, I want a different room, and I have told the gals that work here that!" R28 continued to cry wiping her tears with her Kleenex. R28 then began rubbing her head and stated, "Oh my god I am so tired of this, I have it in the back of my mind to end my life. I am 86 years old, why do I have to put up with this?" R28 stated her roommate (R29), "Is nastier than nasty." At 4:33 p.m., R28 was still crying.

During interview on 10/26/15, at 4:36 p.m. social worker (SW)-A stated everyone at the facility was aware R28 and R29 did not get along. SW-A stated she and the director of nursing (DON) had discussed moving the residents to separate rooms, but felt it would not be a benefit to move either one of them. SW-A stated R28 hallucinates and had made comments about a man being in the room when there hasn't been a man around. SW-A stated she was not aware if R29 was keeping R28 up at night, and stated she had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty rooms all have roommates, and the facility felt they would rather wait for a private room to open before moving R28. SW-A stated she had not

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21475	Continued From page 75 filled out a waiver for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated R28 had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 8/17/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here." During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken to her about moving R28 to a different or private room. During interview 10/26/15, at 6:03 p.m. DON stated a lot of the staff know there, "Is a clash between [R28] and [R29]." The DON stated she was not aware where the social worker was at with the situation between the resident, and the SW made the determination regarding resident room assignments, however, the DON stated, "I am not sure why they haven't moved one of them." DON stated she heard about suicidal comments from R28, but was not aware R28 made a comment about wanting a cord for around her neck, and stated, "If she [R28] said that, she had a plan." A facility policy addressing the responsibilities of social services was requested, but was not provided.	21475		

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21475	Continued From page 76 SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the	21530		12/29/15

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21530	Continued From page 77 pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist recommendations to establish pain medication parameters for use were acted upon for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, no pain, and required extensive assistance with his activities of daily livings (ADLs). The MDS identified R5 had diagnoses including chronic osteomyelitis [an infection of the bone or bone	21530	Corrected.	

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21530	Continued From page 78 marrow] and a non-pressure related foot ulcer. R5's signed Physician Order Report dated 10/6/15, identified medication orders for pain including the following: "Acetaminophen [medication used to treat pain and inflammation] tablet; 650 mg [milligrams] ... DX: [diagnosis] pain ... Every 4 Hours - PRN [as needed]." "Tramadol [narcotic-like pain reliever] - Schedule IV [four] tablet; 50 mg; ... Every 6 Hours - PRN." The signed physician orders did not provide or identify any parameters or direction for when nursing staff should administer the Acetaminophen versus the Tramadol to help control R5's pain. R5's Consultant Pharmacy Drug Regimen Reviews directed the following, "Potential by [sic] insignificant problem," to be acted upon by facility staff: 8/3/15 - " [#5] Please check if there are parameters for using prn Acetaminophen vs [versus] Tramadol?" 9/2/15 - "Repeat MMR [medication regimen review] 8/3/15 #5 - if not addressed." 10/1/15 - "Repeat 8/3/15, MMR #5. Does not appear to be addressed." R5's medical record was reviewed and there was no evidence the consultant pharmacist's recommendations were acted upon as requested on 8/3/15, 9/2/15, and 10/1/15, to assist in clarifying the parameters for R5's pain medication regimen. During interview on 10/26/15, at 9:36 a.m.	21530		

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21530	Continued From page 79 licensed practical nurse (LPN)-A stated she would provide either of the medications to R5 based on how much pain he would complain of, however, she stated established parameters would ensure staff were treating R5's pain consistently. LPN-A reviewed R5's EMAR (electronic medical administration record) and stated there were no established parameters for R5's as needed pain medications. During interview on 10/26/15, at 9:54 a.m. registered nurse (RN)-A stated the nursing staff reviews the pharmacists recommendations after each visit and updates the physician with the pharmacy recommendations. RN-A reviewed R5's medical record and stated the recommendation by the pharmacist to establish parameters for R5's as needed pain medications was not addressed, and stated the recommendations should have been followed up on, "That's an issue." During interview on 10/26/15, at 11:14 a.m. the consulting pharmacist (CP) stated he allows facilities a certain time period for staff to address his recommendations, however, the facility should have addressed the recommendations made on 8/3/15, 9/2/15, and 10/1/15, and stated, "It should be done." A facility policy on medication regimen review and management was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The medical director, consulting pharmacist and/or their designees, could review and/or revise facility policies and procedures related to medication regimen reviews and response to resulting recommendations. Responsible	21530		

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21530	Continued From page 80 personnel could be re-educated on these policies and procedures. The medication regimen of the individual(s) identified in the deficiency could be reviewed with recommendations discussed and acted upon and supporting documentation maintained. Consulting pharmacy recommendations for other residents could be evaluated for appropriate response. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to	21545		12/29/15

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21545	Continued From page 81 be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 1 residents (R45) who had a medication error in which they received the incorrect dosage of insulin that caused low blood sugars with physical symptoms. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated the resident was cognitively intact, had diagnoses of diabetes mellitus, and received daily insulin injections.	21545	Corrected.	

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21545	Continued From page 82 Review of the Buffalo Clinic Telephone order report dated 4/8/15, indicated the facility was instructed by the clinic to notify the physician if R45 had blood sugars below 80 milligram/deciliters (mg/dl), normal blood sugar range 80-120 mg/dl. Review of the Allina Health Clinic Buffalo note which included physician orders dated 4/16/15, indicated R45 was to, "Continue Lantus [long acting insulin] as of the last dosage which was 37 units in the morning. No night time dosage for now." The Lake Ridge Care Center signed Physician Order (PO) Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. The PO did not direct staff to give a night time dose of Lantus. An Allina Health office visit note dated 4/20/15, indicated R45 was to go, "Back on lantus 37 units at bedtime." However, there was no indication R45 had been receiving Lantus at bedtime prior, as the resident had only been taking Lantus 37 units in the morning. Although this PO added 37 units more of insulin, than R45 was currently receiving. The facility did not clarify the significant increase in insulin R45 was to receive from the Allina physician. Review of R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in the morning. However, on 4/20/15, Lantus at HS (at bed time), was implemented, along with the Lantus 37 units in the morning; doubling R45's dose of insulin. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15, to 4/26/15.	21545		

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21545	Continued From page 83 Review of R45's Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45's blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/25/15, indicated the residents blood glucose was checked when the resident was eating breakfast and was only 51 mg/dl. Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/26/15, at 3:30 a.m. indicated the residents blood glucose was 51 mg/dl. Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated, "Resident had low BS (blood sugar) this morning; was sweating and shaky. She had a BS of 38." The physician was called at 8:44 a.m. and updated on R45's low blood sugar. A Buffalo Clinic Telephone Communication sheet indicated on 4/27/15, at 8:42 a.m. Lake Ridge called the clinic regarding R45's low BS in morning of 38 mg/dl. The Telephone Communication form indicated at 4:46 p.m. Lake Ridge called the clinic back wanting to know if the patient should actually be on 37 units of Lantus at bed time, as the facility just noticed the insulin orders did not match up.	21545		

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21545	Continued From page 84 A Buffalo Clinic Telephone order report dated 4/27/15, medical doctor (MD)-B indicated at 5:34 p.m., "Discussed with [staff] by phone. As of 4/20/15, visit had written to return to Lantus 37 units at bedtime, when it should have been once daily MORNING DOSE> Clarified with [staff] patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." MD-B ordered Lantus 37 units once daily in the morning as prior to hospital stay. R45's Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated, "Resident had been receiving Lantus 37 units BID (twice daily) since 4/20, miscommunication written upon return from appointment. Spoke with [MD-B] and the HS dose has been d/c'd [discontinued] and will continue the 37 units in AM (disregard previous T.O. (telephone order)." During interview 10/26/15, at 9:30 a.m. director of nursing (DON) stated she was not aware of the insulin medication error that had occurred for R45, and stated she was unable to locate a medication error report. The DON stated the nurses should have called the physician when they noted the order for Lantus to be given at HS on 4/20/15, since the resident had not received that dose before, and the order was doubling the current insulin she was receiving. The DON stated that she had not checked any other residents orders to see if this was reoccurring problem. DON stated she did not do any staff training related to the significant medication error, because she was not aware the error occurred until survey on 10/26/15, six months after the error occurred. Although R45 was previously on Lantus 37 units	21545		

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LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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21545	Continued From page 85 in morning only, and had a history of low BS after the order to double the residents insulin dose on 4/20/15, the facility failed to clarify with the physician the additional order of Lantus 37 units at HS, nor did the facility contact the physician when R45 had low blood sugars on 4/22/15, 4/25/15, and 4/26/15. The facility did not contact the physician until 4/27/15, 7 days after R45's insulin dose was doubled, when the resident had a low blood sugar of 38 and experienced symptoms. Also, there was no indication they looked at other residents, and educated staff to prevent other potential medicaiton errors. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to medication administration, preventing significant medication errors and/or medication transcription processes. Responsible personnel could be re-educated on these policies and procedures. The medication regimen for the individual(s) identified in the deficiency could be reviewed for accuracy and appropriateness, with supporting documentation maintained. An investigation could be completed to determine the root cause of this significant medication error, with corrective action implemented to prevent similar errors from occurring in the future. The medication regimens of other residents could be evaluated for appropriate transcription processes and administration. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21545		

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21800	Continued From page 86	21800		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R98)	21800	Corrected.	12/29/15

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21800	Continued From page 87 were provided the required notice of Medicare non-coverage upon termination of the covered services. Findings include: A facility Admission/Leave/Discharge Tracking Report dated 4/15/15, to 5/25/15, identified R98 was admitted with a payment source of, "Medicare Part A," and remained in the facility for 32 days. R98's medical record was reviewed, however, no information was identified she had been provided the required notices of Medicare non-coverage prior to her Medicare services ending. During interview on 10/26/15, at 2:14 p.m. social worker (SW)-A stated there was no documented evidence R98 was provided a Notice of Medicare Provider Non-Coverage (CMS-10123). R98 was admitted for a therapy stay at the facility, and should have been given the denial notice two days before her covered services ended. During follow up interview on 10/26/15, at 2:55 p.m., SW-A stated the facility did not have a policy on ensuring the liability notices were given correctly, rather they, "Just follow Medicare guidelines." SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to liability and appeal rights notices for Medicare non-coverage. Responsible personnel could be re-educated on these policies and procedures. Appropriate notices could be provided for individual(s) identified in the deficiency, with supporting documentation	21800		

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21800	Continued From page 88 maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21800		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family	21830		12/29/15

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21830	Continued From page 89	21830		

member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated

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21830	Continued From page 90 emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for choices. Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, indicated he was cognitively intact, needed assist of two staff with bathing, and it was "very important" to be able to chose the method in which he was bathed. R73's care plan dated 9/25/15, identified he had been admitted in September 2015, but did not identify any preferences or assistance R73 required with bathing. R73's undated Nursing Assistant Care Sheet indicated he received a tub bath on Thursday by an outside agency. During interview 10/21/15, at 10:02 a.m. R73 stated hospice is to be giving me two baths a week and the facility is supposed to also be giving	21830	Corrected.	

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me two baths a week. R73 then stated, "I have only received two baths from the facility since I have been here."
The facilities Mill Creek Bridge Weekly Bath and Vital List dated 9/21/15 to 10/22/15, identified the following:
> The week of 9/21/15 to 9/27/15, R73 was not identified on the bath list.
> The week of 9/28/15 to 10/4/15, R73 continued to not be identified on the bath list.
> The week of 10/5/15 to 10/11/15, R73 was scheduled to receive four baths, but only had one bath documented as being completed.
> The week of 10/12/15 to 10/18/15, R73 was again scheduled to receive four baths, but only had one bath documented as being completed.
> The week of 10/19/15 to 10/22/15, R73 was scheduled to receive three baths, but only had two baths documented as being completed.
The bath listing identified R7 received two baths from the facility and two baths from the outside agency, a total of 4 out of the 11 baths he should have received.
During interview 10/23/15, at 9:15 a.m. nursing assistant (NA)-F stated the staff do the best they can, but added, "We do not have a bath aide and we just can't get all of them done so some of the baths have been missed. That's all I can say."
During interview 10/23/15, at 9:21 a.m. registered nurse (RN)-A stated R73 should have received his bath according to his choice adding if it was not documented on the listing, it was not completed.
A facility policy on choices was requested, but none was provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review and/or revise facility policies and procedures related to resident choice and participation in

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21830	Continued From page 92 planning of their bathing schedules. Responsible personnel could be re-educated on these policies and procedures. Appropriate accommodations could be made to honor the bathing preferences of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for preferences with regard to their bathing schedules. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21830		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide timely follow-up to the resident council groups grievance as concerned with inadequate staffing in the facility. This affected 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. Findings include: During the recertification survey, the resident council minutes were reviewed and identified the following: The resident council minutes dated 7/28/15,	21870	Corrected.	12/29/15

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21870	Continued From page 93 indicated under nursing R27, R19, R45, "All feel we do not have enough nursing help due to how long it takes for their call lights to be answered. Writer [activity director (AD)] explained the difference between cutting hours due to census vs. [versus] being short staffed." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R19, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/12/15, from the director of nursing (DON) provided a response which identified, "There are times of the day and night when many residents are requesting assistance at the same time. We are getting to each one of them as quickly as possible we are adequately staffed. Some employees are new and work a little slower while they are learning." The resident council minutes dated 8/13/15, identified, "Updates on last meeting concerns" were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention too! Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes dated 9/29/15, identified, "Council members are concerned about staffing. Writer [AD] explained staffing.	21870		

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21870	Continued From page 94 [R21] had concern about waiting to go to his meal for too long. Writer explained about the requirement for a NAR's [nursing assistant, registered] to be able to sit with residents who need assist to eat and that this way likely the reason he had to wait." There was no evidence the repeated concerns regarding inadequate staffing at the facility were addressed by the management team. During interview on 10/23/15, at 12:23 p.m. R45 stated she did not feel the concerns voiced during the council meetings were addressed, adding, "They are so short staffed here at the facility sometimes I have to wait 45 minutes for the staff to help me you see I am immobile and need help to get on the bed pan to have a BM [bowel movement] and when they are late, I can't wait so I have an accident in the bed and that is not pleasant for me." During interview on 10/23/15, at 9:30 a.m. the AD who stated she is in charge of the resident council meetings. AD stated, "The residents do complain about the staffing here and it's a problem everywhere. I let the DON know about their concerns. I always tell them we are trying and with so many residents sometimes you just have to wait." Although R27, R19, R45, R35 and R21 had complaints of staffing on 7/28/15, their concerns continued at the 8/13/15 and 9/29/15 resident council meetings with no objective, measurable plan being identified to resolve there concerns of staffing. The facility Grievances and Complaints policy dated 1/12/12, indicated "it is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve	21870		

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21870	Continued From page 95 our facility." The policy further indicated "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to resident council grievances. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts toward resolution of resident council grievances could be made, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the	21880		12/29/15

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21880	Continued From page 96 Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to resolve an individual grievance for 1 of 1 residents (R45) who had expressed concerns over lift placement and bruising. Findings include:	21880	Corrected.	

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21880	Continued From page 97 R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated R45 was cognitively intact and required assistance of two staff for transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously... Had concerns about lift with sling placement and bruising [R45] felt she wasn't taken seriously." The action form indicated it was given to the DON. The form indicated the director of nursing (DON) response: "[R45] was not feeling well and gets paranoid/depressed with illness. this writer did visit with her and that she down played the concern." During interview on 10/22/15, at 2:10 p.m. the DON stated she was aware of R45's concern but did not feel it was a big deal. The DON stated it was about the lift but never investigated if there was bruising or how the staff were transferring the resident. The DON had not implemented any actions in effort to resolve R45's concern with the lift. During interview on 10/23/15, at 12:23 p.m. with R45 stated the staff did not always listen to her when she made a concern. R45 stated a few months ago when she was being transferred from her ceiling lift, the strap was not connected correctly and it slid down on her right arm, causing a skin tear and bruising. R45 was "irritated" because she "made a grievance in resident council", but didn't "think anything was done about it." A facility Grievances and Complaints policy dated 1/12/12, indicated, "It is the policy of Lake Ridge	21880		

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21880	Continued From page 98 Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." Further, the policy indicated, "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to individual resident grievances. Responsible personnel could be re-educated on these policies and procedures. Grievances could be addressed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate response to voiced grievances. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 99	21980		

individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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21980	Continued From page 100 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator, state agency and thoroughly investigated for 3 of 5 residents (R45, R104 and R131) whose allegations were reviewed. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated she was cognitively intact and required assist of two staff with transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously" R45 had "concerns about lift with sling placement and bruising," and, "felt she wasn't taken seriously." The form identified it was given to the DON who responded, "Res [resident] was not feeling well and gets paranoid/depressed with illness ... did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern. The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any bruising on R45.	21980	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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21980	Continued From page 101 During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was no indication the adminstrator and the state agency were immediately notifed, nor had an investigation been completed of the allegation. R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door and overheard a mans loud voice that was not resident yelling and swearing. Writer was unable to hear what was all being said but did her the word "Fuck", and "your and Asshole" in an angry tone of voice. Writer immediately went into room with nurse and saw resident's family member (FM)-A was yelling at resident. Resident was asked if he wanted FM-A to leave. Resident said yes. FM-A was asked to leave several times by writer before he complied with leaving. FM-A at the time was holding up his phone that had a light and was pointed towards resident. Resident was asked if his FM-A was video taping him. Resident stated yes. Writer asked residnet if FM-A had his permission to do this and resident stated "no".	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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21980	Continued From page 102 Resident also stated that (FM-A) has, in the past, been physically abusive to him and has also threatened to kill him in the past while at residents home. Resident stated that FM-A had actually pushed him into a bonfire at residents home to try to kill him, and he still had the scars to show for it. Resident express that he didn't know if he wanted FM-A back here at the facility since he has been the only one that has been helping him. Resident also let writer know that FM-A now had keys to his home, truck and was refusing to give those back. FM-A told the resident, "you will have to break into your house if you think you are going back there". Resident also stated FM-A has his laptop and refusing to give that back. The investigation was submitted to the state agency on 7/01/15. During interview 10/26/15, at 6:13 p.m. with the DON who stated the incident should have been immediately reported and she did not know why it had been reported late. Although the incident occurred on 6/26/15, the facility did not report the incident to the administrator and state agency until two days after the incident, on 6/29/2015. R131's quarterly MDS dated 2/25/15, indicated she was moderately cognitively intact and needed extensive assist of two with transfers. An Investigative Report dated 4/5/15, indicated that on 4/3/15 R131 had a, "exp. large discolored area to the lateral left breast" which measured 10 cm (centimeter) by 8 cm in size. R131 was reassessed for her ability to continue to be transferred in this type of device, and R131 was determined to require a hoyer lift for transfers.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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21980	Continued From page 103 The administrator and the state agency was informed of the incident on 4/5/15 two days later and the investigation was submitted to the state agency on 4/13/15, 10 days after the incident occurred and identified the injury was from a mechanical lift. During interview 10/22/15, at 2:17 p.m. DON stated the investigation was sent late and didn't know why it was sent late "maybe it was a computer glich". Further, the DON stated because of the size and the location, the incident needed to be reported. Although the injury was noted on 4/3/15, the facility failed to inform the administrator and and the state agency two days later and the investigation was not reported until 10 days later. The facilities Vulnerable Adult Abuse Prohibition Policy and Procedure revised November 2011, indicated "Each employee is responsible to report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The administrator will be notified immediately by on of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." SUGGESTED METHOD OF CORRECTION:	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 104 The director of nursing or designee, could review and/or revise facility policies and procedures related to abuse prohibition. Responsible personnel could be re-educated on these policies and procedures. Reports of abuse/ neglect/ injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00714 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20130	Correction	ID Prefix	20255	Correction	ID Prefix	20265	Correction
Reg. #	MN Rule 4658.0050 Subp. 1	Completed	Reg. #	MN Rule 4658.0070	Completed	Reg. #	MN Rule 4658.0085	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	20565	Correction	ID Prefix	20800	Correction	ID Prefix	20830	Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0510 Subp. 1	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	20840	Correction	ID Prefix	20860	Correction	ID Prefix	20910	Correction
Reg. #	MN Rule 4658.0520 Subp. 2 B	Completed	Reg. #	MN Rule 4658.0520 Subp. 2 F.	Completed	Reg. #	MN Rule 4658.0525 Subp. 5 A.B	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21330	Correction	ID Prefix	21375	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0725 Subp. 2 A&B	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21475	Correction	ID Prefix	21530	Correction	ID Prefix	21545	Correction
Reg. #	MN Rule 4658.1005 Subp. 1	Completed	Reg. #	MN Rule 4658.1310 A.B.C	Completed	Reg. #	MN Rule 4658.1320 A.B.C	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	BF/mm	12/06/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00714 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	21800	Correction	ID Prefix	21830	Correction	ID Prefix	21870	Correction
Reg. #	MN St. Statute144.651 Subd. 4	Completed	Reg. #	MN St. Statute 144.651 Subd. 10	Completed	Reg. #	MN St. Statute 144.651 Subd. 18	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21880	Correction	ID Prefix	21980	Correction			
Reg. #	MN St. Statute 144.651 Subd. 20	Completed	Reg. #	MN St. Statute 626.557 Subd. 3	Completed			
LSC		12/29/2015	LSC		12/29/2015			

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	BF/mm	12/06/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/26/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 28WI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00714

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245513**

2.STATE VENDOR OR MEDICAID NO.
(L2) **066663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE RIDGE CARE CENTER OF BUFFALO**
(L4) **310 LAKE BOULEVARD**
(L5) **BUFFALO, MN** (L6) **55313**

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) **02/01/2004**

6. DATE OF SURVEY **01/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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):

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 01/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/14/2015
(L33)

Posted 02/12/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245513
January 28, 2016

Mr. Jason Nelson, Administrator
Lake Ridge Care Center of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

Dear Mr. Nelson:

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

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

Effective December 29, 2015 the above facility is certified for or recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 28, 2016

Mr. Jason Nelson, Administrator
Lake Ridge Care Center of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

RE: Project Number S5513025 & H5513019

Dear Mr. Nelson:

On November 19, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 24, 2015. (42 CFR 488.422)

On December 3, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $2000.00 for the deficiency cited at F250, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of $2000.00 for the deficiency cited at F309, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of $5700.00 for the deficiency cited at F323, (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 26, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on October 26, 2015 that included an investigation of complaint number H5513019. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On January 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on October 26, 2015, as of December 29, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring

effective December 29, 2015.

However, as we notified you in our letter of November 19, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 3, 2015:

- Per instance civil money penalty of $2000.00 for the deficiency cited at F250, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of $2000.00 for the deficiency cited at F309, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of $5700.00 for the deficiency cited at F323, (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 26, 2016 be rescinded as of December 29, 2015. (42 CFR 488.417 (b))

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245513 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0157	Correction	ID Prefix F0166	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.10(b)(11)	Completed	Reg. # 483.10(f)(2)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0167	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix F0244	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.15(c)(6)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0250	Correction	ID Prefix F0282	Correction	ID Prefix F0285	Correction
Reg. # 483.15(g)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.20(m), 483.20(e)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0315	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(d)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	01/28/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245513 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323	Correction	ID Prefix F0333	Correction	ID Prefix F0353	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(m)(2)	Completed	Reg. # 483.30(a)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0356	Correction	ID Prefix F0371	Correction	ID Prefix F0412	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.55(b)	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0428	Correction	ID Prefix F0441	Correction	ID Prefix F0490	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.65	Completed	Reg. # 483.75	Completed
LSC	12/29/2015	LSC	12/29/2015	LSC	12/29/2015
ID Prefix F0520	Correction				
Reg. # 483.75(o)(1)	Completed				
LSC	12/29/2015				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	01/28/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/26/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245513	A. Building 01 - MAIN BUILDING 01 B. Wing	12/1/2015

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 12/01/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 01/28/2016	SIGNATURE OF SURVEYOR 34764	DATE 12/01/2015
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/22/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 28, 2016

Mr. Jason Nelson, Administrator
Lake Ridge Care Center of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

Re: Reinspection Results - Project Number S5513025 & H5513019

Dear Mr. Nelson:

On January 21, 2016 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 October 26, 2015, that included an investigation of complaint number H5513019, with orders received by you on November 19, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00714 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20130	Correction	ID Prefix	20255	Correction	ID Prefix	20265	Correction
Reg. #	MN Rule 4658.0050 Subp. 1	Completed	Reg. #	MN Rule 4658.0070	Completed	Reg. #	MN Rule 4658.0085	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	20565	Correction	ID Prefix	20800	Correction	ID Prefix	20830	Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0510 Subp. 1	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	20840	Correction	ID Prefix	20860	Correction	ID Prefix	20910	Correction
Reg. #	MN Rule 4658.0520 Subp. 2 B	Completed	Reg. #	MN Rule 4658.0520 Subp. 2 F.	Completed	Reg. #	MN Rule 4658.0525 Subp. 5 A.B	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21330	Correction	ID Prefix	21375	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0725 Subp. 2 A&B	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21475	Correction	ID Prefix	21530	Correction	ID Prefix	21545	Correction
Reg. #	MN Rule 4658.1005 Subp. 1	Completed	Reg. #	MN Rule 4658.1310 A.B.C	Completed	Reg. #	MN Rule 4658.1320 A.B.C	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	BF/KJ	01/28/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00714 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	21665	Correction	ID Prefix	21800	Correction	ID Prefix	21805	Correction
Reg. #	MN Rule 4658.1400	Completed	Reg. #	MN St. Statute144.651 Subd. 4	Completed	Reg. #	MN St. Statute 144.651 Subd. 5	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21830	Correction	ID Prefix	21870	Correction	ID Prefix	21880	Correction
Reg. #	MN St. Statute 144.651 Subd. 10	Completed	Reg. #	MN St. Statute 144.651 Subd. 18	Completed	Reg. #	MN St. Statute 144.651 Subd. 20	Completed
LSC		12/29/2015	LSC		12/29/2015	LSC		12/29/2015
ID Prefix	21980	Correction						
Reg. #	MN St. Statute 626.557 Subd. 3	Completed						
LSC		12/29/2015						

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	BF/KJ	01/28/2016	35575	01/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/26/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 28WI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00714

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245513**

2.STATE VENDOR OR MEDICAID NO.
(L2) **066663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE RIDGE CARE CENTER OF BUFFALO**
(L4) **310 LAKE BOULEVARD**
(L5) **BUFFALO, MN** (L6) **55313**

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) **02/01/2004**

6. DATE OF SURVEY **10/26/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (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):

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 12/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/14/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Electronically delivered
November 19, 2015

Mr. Jason Nelson, Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

RE: Project Number S5513025, H5513019

Dear Mr. Nelson:

On October 26, 2015, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 26, 2015 extended survey, investigation of complaint number H5513019 was conducted.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ)** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the October 26, 2015 extended survey the Minnesota Department of Health completed an investigation of complaint number H5513019 that was found to be substantiated at F323.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on October 23, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the 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
Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338 Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 24, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F250 (S/S=G), effective October 26, 2015 (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F309 (S/S=G), effective October 26, 2015 (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F323 (S/S=J), effective October 26, 2015 (42 CFR 488.430 through 488.444)

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lake Ridge Care Center Of Buffalo is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 26, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by January 26, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(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 A survey was conducted by the Minnesota Department of Health on October 19, 2015, through October 26, 2015. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response after a resident obtained nine second degree burns from hot coffee that spilled onto his left foot/ankle, which resulted in the high potential for harm or death. The facility administrator and director of nursing (DON) were notified of the immediate jeopardy on 10/21/15, at 6:06 p.m., which began on October 10 2015, at 4:50 p.m. after the resident recieved second degree burns from coffee. The IJ was removed on October 23, 2015, at 8:24 a.m. In addition a complaint investigation was completed for H5513019, and was substantiated which resulted in a deficiency at F353. 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident	F 156		12/29/15

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

Electronically Signed | 11/27/2015

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F 156	Continued From page 1	F 156		

understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures

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F 156	Continued From page 2 for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R98) were provided the required notice of Medicare non-coverage upon termination of the covered services. Findings include: A facility Admission/Leave/Discharge Tracking Report dated 4/15/15, to 5/25/15, identified R98 was admitted with a payment source of, "Medicare Part A," and remained in the facility for 32 days. R98's medical record was reviewed, however, no information was identified she had been provided the required notices of Medicare non-coverage prior to her Medicare services ending. During interview on 10/26/15, at 2:14 p.m. social worker (SW)-A stated there was no documented evidence R98 was provided a Notice of Medicare Provider Non-Coverage (CMS-10123). R98 was admitted for a therapy stay at the facility, and should have been given the denial notice two days before her covered services ended. During follow up interview on 10/26/15, at 2:55 p.m., SW-A stated the facility did not have a policy on ensuring the liability notices were given correctly, rather they, "Just follow Medicare guidelines."	F 156	F156-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to insure residents are provided the required notice of Medicare non-coverage upon termination of the covered services. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident is no longer on Medicare coverage. 2.Actions taken to identify other potential residents having similar occurrences: Reviewed all residents involved with Medicare back to the exit of the survey to ensure other residents that could potentially have been affected were identified. 3.Measures put in place to ensure deficient practice does not recur:	

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F 156	Continued From page 4	F 156	Education was completed on 2 Nov 15 with Social Workers and MDS Coordinator to address the change in process for completing Medicare Denials using CMS Medicare guidelines as the resource. Social Worker will be notified at bi-weekly Medicare Meeting of upcoming denials and administer denials timely, followed by scanning into the medical record. 4.Effective implementation of actions will be monitored by: MDS Coordinator will perform weekly audits to insure Medicare denials have been issued timely and scanned into the resident medical record. Findings will be reported to the Quality Assurance meetings for the next two quarters. 5.Those responsible to maintain compliance will be: The Social Worker will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 2015	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157		12/29/15

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F 157	Continued From page 5 status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 residents (R118) who expressed concerns of unmanaged pain and 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118 had no cognitive impairment, required assistance to complete most activities of daily living (ADLs), did not receive scheduled pain medications, however,	F 157	F157-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.	

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F 157	Continued From page 6 received as needed (PRN) pain medication and non-pharmacological interventions to manage pain. The MDS also identified the pain made it difficult to sleep at night, and limited her day to day activity, was frequent, and one arterial or venous ulcer. R118's pain Care Area Assessment (CAA) dated 8/24/15, identified R118 had a stasis ulcer on her right leg that was infected and continued to drain large amounts of fluid. The assessment indicated, "Staff will continue to monitor for pain and update MD [medical doctor] as needed." During observation and interview on 10/21/15, at 11:30 a.m. R118 was rubbing her right lower leg, and applying an ice pack to the same area. R118 complained of unmanaged pain related to an open sore to her right, lower leg stating she had just had a routine dressing change completed to the area, and the pain during these dressing changes, "Hits over a 10" on a zero (0) to 10, numeric pain rating scale (0 = no pain, 10 = the most intense pain imaginable). R118 stated she was treated with pain medication prior to having the dressing changed only, "If we [staff and her] think of it." On 10/22/15, at 9:28 a.m. R118 was observed in her room, receiving her morning medications from licensed practical nurse (LPN)-F. Both LPN-F and R118 confirmed she had just received a pain medication (Gabapentin 300 mg, pain medication to treat nerve pain) and she typically liked to wait "for her pain pill to kick in," before her dressing change was completed. R118 asked LPN-F to return in a half hour to complete her dressing change and to bring an ice pack. At 10:01 a.m., R118 stated, "[Her pain medication]	F 157	It is the policy of Lake Ridge Care Center to update the medical doctor in a timely fashion. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 118's medical record for pain management was reviewed on 28 Oct 15. Medical providers contacted several times since survey for review and adjustment of pain management. Resident 45's insulin/blood sugar orders were reviewed and the medical provider was updated multiple times since 30 Oct 15 to obtain orders for blood sugar parameter notification if symptomatic. 2.Actions taken to identify other potential residents having similar occurrences: All residents have the potential for pain. Residents with uncontrolled pain were reviewed to ensure the physician was aware of any changes and was updated with the changes related to pain. Resident's with diagnosis of diabetes have the potential for blood sugars outside of parameters. Resident's blood sugars were reviewed for past month to ensure the physician was aware of changes and was updated with the changes if needed. 3.Measures put in place to ensure deficient practice does not recur:	

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F 157	Continued From page 7 never quite cuts it... when they start scraping, there's nothing [that could stop the pain]." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m. LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, it's starting to burn." LPN-F asked	F 157	Education on notification to medical provider with condition change, diabetic/ blood sugar management and pain management was completed by 13 Dec 15 for licensed nurses and TMAs. Morning IDT stand up meetings implemented on 30 Dec 15 to monitor for change in conditions and MD notification. 4.Effective implementation of actions will be monitored by: Will audit ten residents with changes in condition related to blood sugars and pain with wound treatment to ensure medical provider was updated and will also audit ten MARs/TARs monthly for three months for pain effectiveness and blood sugars outside parameters to ensure medical provider was updated. Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	

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F 157	Continued From page 8 R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated, "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118. During interview on 10/22/15, at 10:51 a.m. LPN-F stated R118 had verbal and non-verbal pain indicators during the dressing change, was typical for her. LPN-F stated R118's doctor and nurse practitioner were aware of R118's pain, and R118's pain management regimen consisted of offering Ultram (an analgesic medication) first, then oxycodone (a narcotic pain medication) if the Ultram was not effective. LPN-F stated the resident could also have ice at any time to help relieve the pain. LPN-F stated she was not aware of any changes in R118's pain medication, and was not sure if anyone had discussed a change in medication with R118's physician.	F 157	Completion date for certification purposes only is: 29 Dec 15	

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F 157	Continued From page 9	F 157		

R118's physician progress notes from 8/17/15, to 10/26/15, included the following:

R118's New Patient History and Physical Examination, completed by medical doctor (MD)-A dated 9/3/15, indicated the resident had osteoarthritis affecting her knees, shoulder, and hip, with residual pain post knee and hip arthroplasties. The report did not further address her pain.

On 8/24/15, nurse practitioner (NP)-A noted R118 had complaints of pain to her right lower extremity with dressing changes.
On 9/10/15, NP-A noted the appearance of R118's right lower leg and reviewed the dressing treatments. NP-A noted, "Discussed pain control will add oxycodone for mod [moderate]/severe pain."
On 9/23/15, a Wound Care/ Hyperbaric Medicine History and Physical noted, there was a wound on the anteromedial portion of (R118's) right lower leg that measured 11 x (by) 12.5 0.1 cm (centimeters) and was very tender to touch. They initially tried to dress the wound with Medihoney; however, the patient developed a lot of discomfort with this. R118 was given a oxycodone and once her pain got better her wound was then dressed.
On 10/8/15, NP-A addressed R118's chronic right lower leg ulcer. NP-A noted, "Resident today says, 'I'm ok,' but frowning and awaiting R [right] LE [lower extremity] dressing [change]. C/o [Complains of] pain to R LE.
On 10/19/15, NP-A noted R118's emergency room visit was reviewed. The note did not address R118's stasis ulcer.

Review of R118's current physician orders dated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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10/26/15, directed the following wound treatment and pain management regimen:
·Wound treatment to stasis ulceration on right lower extremity- cleanse wound, and change dressing daily and PRN.
·Gabapentin 300 milligrams (mg), twice daily for peripheral neuropathy/ polyneuropathy.
·Ultram 50 mg, every four hours PRN for pain, for chronic pain syndrome.
·Oxycodone 5 mg, every four hours PRN for pain not relieved by Ultram, for chronic pain syndrome.

Review of R118's Electronic Medication Administration Record (EMAR) from 9/1/15, to 10/25/15, identified the following as PRN pain medications were administered for right, lower extremity and leg pain.

The September 2015 EMAR identified R118 took a total of 103 doses of PRN pain medication. She took 68 doses of Ultram 50mg, which were effective 42 of 68 opportunities; slightly effective 14 of 68; not effective 2 of 68, and other, which was not identified for 1 of 68 opportunities.

R118 had 35 doses of PRN oxycodone 5mg in September 2015, which was effective 14 out of 35 opportunities; slightly effective 3 out of 35; and other which was not identified 3 out of 35, opportunities.

The October 2015 EMAR identified R118 was administered 100 doses of pain medication for right, lower extremity leg pain. She took 49 doses of Ultram 50mg, which was effective 18 out of 49 opportunities; slightly effective 17 out of 49; and not effective 6 out of 49 opportunities.

R118 had 51 doses of PRN oxycodone 5mg, in

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October 2015 which was effective 34 out of 51 opportunities; slightly effective 11 out of 51; not effective 5 out of 51 and other, which was not identified, 1 out of 51 opportunities.

Review of the EMAR PRN administration times from September to October 2015, did not correlate with R118's dressing changes, because the dressing changes were not consistently documented.

Even though R118 was administered 203 doses of PRN pain medication, taken in 55 days, approximately 3.7 doses of PRN pain medication each day, along with her scheduled Gabapentin 300 mg twice a day. R118 continued to experience significant pain with her dressing changes.

Review of R118's nursing progress notes from 9/6/15 through 10/17/15, included the following potential indicators of poor pain control:
On 9/7/15, at 1:39 p.m. registered nurse (RN)-C noted, "[R118] refused to have dressing put on in fear that it would start hurting again... [R118] is leaving it open to air. PRN given."
On 9/8/15, 11:10 p.m. LPN-C noted, "[R118] c/o pain to RLE. [R118] is unable to have any more prn pain medication for another 2 [two] hours. On call physician... said to use standing order of Tylenol. Will administer Tylenol and continue to monitor."
On 9/19/15, at 1:12 a.m. LPN- D noted, "[R118] c/o 7/10 pain right lower extremity; somewhat relieved with prn tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]."
On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, 'It burns so bad when drainage is left on my leg.'"

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On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds were given closer together."
On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication."

During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's physician was at the facility every Thursday and he was responsible for monitoring to ensure her pain management regimen was sufficiently effective. When asked when the last time was that R118's physician was updated on and/or addressed R118's pain management, RN-H confirmed the most recent notation of the physician/ nurse practitioner having commented on her pain in physician progress notes, was on 10/8/15. RN-H stated that she was aware R118 had significant pain with dressing changes, but believed the current pain management regimen was effective for her. RN-H denied any reports of pain management concerns for R118, from the facility nurses or NAs and would expected her staff would have updated the physician if/when they identified unmanaged pain, to makes changes to her pain regime.

R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily.

Lake Ridge Care Center signed Physician Order Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning.

An Allina Health office visit note dated 4/20/15,

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indicated under "Your Plan" back on lantus 37 units at bedtime.

R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in morning with a start date of 4/17/15 and Lantus at HS (at bed time), with a start date of 4/20/15. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15 to 4/26/15.

The Buffalo Clinic Telephone order report dated 4/8/15, indicated at 8:58 a.m. received call from Lake Ridge care center, had blood sugar of 67 today, and told per orders to call if below 80.

Per the Buffalo Clinic Telephone order report dated 4/27/15, Dr. Anderson indicated at 5:34 p.m., "Discussed with (staff) by phone. As of 4/20/15 visit, had written to return to Lantus 37 units at bedtime when it should have been once daily MORNING DOSE> Clarified with (staff) patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." Dr. Anderson then ordered Lantus 37 units once daily in the morning as prior to hospital stay.

Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45 blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood glucose.

Resident Progress Note dated 4/25/15, indicated a blood sugar was only 51 while R45 was eating her breakfast meal. Review of the medical record did not indicate the physician was notified of the low blood sugar.

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F 157	Continued From page 14 Resident Progress Note dated 4/26/15, at 3:30 a.m. blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated "Resident had low BS (blood sugar) this morning was sweating and shaky. she had a BS of 38. The physician was called at 8:44 a.m." Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated "Resident had been receiving Lantus 37 units BID (twice a day) since 4/20, miscommunication written upon return from appointment. Spoke with Dr. Anderson and the HS dose has been d/c'd (discontinued) and will continue the 37 units in AM." During interview 10/26/15, at 9:30 a.m. with the DON who stated she was not aware of the insulin discrepancy and stated she was unable to locate a medication error. The DON further stated the nurses should have called the physician when they noted the order for Lantus to be given at HS since she was not on that before and because of her low blood sugars. Although R45 had an order to notify the physician if blood sugars were below 80, the facility did not notify the physician of the three low blood sugars. The facility's Change in Resident's Condition Or Status policy dated 7/14, directed "POLICY: It is the policy of Elim Care, Inc. to promptly notify the resident, his or her Attending Physician, and representatives of changes in the resident's medical/mental condition and/or status."	F 157		

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to attempt to resolve an individual grievance for 1 of 1 residents (R45) who had expressed concerns over lift placement and bruising. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated R45 was cognitively intact and required assistance of two staff for transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously... Had concerns about lift with sling placement and bruising [R45] felt she wasn't taken seriously." The action form indicated it was given to the DON. The form indicated the director of nursing (DON) response: "[R45] was not feeling well and gets paranoid/depressed with illness. this writer did visit with her and that she down played the concern." During interview on 10/22/15, at 2:10 p.m. the DON stated she was aware of R45's concern but did not feel it was a big deal. The DON stated it was about the lift but never investigated if there	F 166	F166-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to resolve expressed grievances prompted by residents. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Weekly skin check completed on Resident 45 on 28 Oct 15 with no further bruises noted. Interviewed Resident 45 on 23 Nov 15 to ensure transfers were occurring according to resident preferences. Transfer observation with	12/29/15

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F 166	Continued From page 16 was bruising or how the staff were transferring the resident. The DON had not implemented any actions in effort to resolve R45's concern with the lift. During interview on 10/23/15, at 12:23 p.m. with R45 stated the staff did not always listen to her when she made a concern. R45 stated a few months ago when she was being transferred from her ceiling lift, the strap was not connected correctly and it slid down on her right arm, causing a skin tear and bruising. R45 was "irritated" because she "made a grievance in resident council", but didn't "think anything was done about it." A facility Grievances and Complaints policy dated 1/12/12, indicated, "It is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." Further, the policy indicated, "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager."	F 166	Resident 45 will be completed periodically as facility does mechanical lift transfer audits. 2.Actions taken to identify other potential residents having similar occurrences: The facility Vulnerable Adult log and Resident Council minutes from October were reviewed by Administrator. Interviewable residents will be interviewed by for potential VA concerns and non-interviewable resident's weekly skin checks will be viewed to determine injuries of unknown origin and follow-up needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur: Grievance and Complaints policy and form was reviewed and revised by 30 Oct 15. Staff education on handling resident grievances and concerns and nursing staff education on transfer techniques with mechanical lift will be completed on 13 Dec 15. Administrator will review Resident Council minutes after Resident Council meetings beginning in November 2015. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Facility will complete five NAR Care Observations weekly for three months. Audits will be completed on	

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F 166	Continued From page 17	F 166	grievance log and Resident Council minutes monthly for three months. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure the most recent State survey results were readily available for resident and family review. This had	F 167	F167-C Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response	12/29/15

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F 167	Continued From page 18 the potential to affect all 48 residents, visitors and staff who wished to review the information. Findings include: During the initial tour of the facility on 10/19/15, at 6:42 p.m. a clear plastic holder was attached to the wall by the entry way which contained a white three ring binder. The binder contained State survey results dated 10/24/13 (two years prior). When interviewed on 10/26/15, at 5:30 p.m. the administrator stated he or the licensed social worker (LSW)-A were responsible to update the results, and the 2014 survey should have been displayed.	F 167	and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to post survey results so that they are available for residents and families to review. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The most recent survey results were posted on 26 Oct 15. 2.Actions taken to identify other potential residents having similar occurrences: All residents had potential to be affected by alleged deficient practice. 3.Measures put in place to ensure deficient practice does not recur: Staff education addressing CMS requirements for posting of most recent survey results was completed by 13 Dec 15. Survey book will be updated with new survey result by Administrator as they are available. 4.Effective implementation of actions will be monitored by:	

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F 167	Continued From page 19	F 167	Facility receptionist will verify correct survey results are posted on a weekly basis and will complete the audit tool for three months. The results collected will be presented to the next Quality Assessment & Assurance Committee quarterly meeting. At that time, the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		12/29/15

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F 225	Continued From page 20 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator, state agency and thoroughly investigated for 3 of 5 residents (R45, R104 and R131) whose allegations were reviewed. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated she was cognitively intact and required assist of two staff with transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she	F 225	F225-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center	

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F 225	Continued From page 21 brings a complaint to a nurse she feels they do not take her seriously" R45 had "concerns about lift with sling placement and bruising," and, "felt she wasn't taken seriously." The form identified it was given to the DON who responded, "Res [resident] was not feeling well and gets paranoid/depressed with illness ... did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern. The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any bruising on R45. During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was no indication the adminstrator and the state agency were immediately notifed, nor had an investigation been completed of the allegation.	F 225	to report allegations of abuse, neglect and injuries of unknown origin immediately to the administrator and state agency. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Incident for Resident 45 was submitted on 27 Nov 15 to OHFC. Investigation and follow-up will be completed per regulatory compliance. Resident 131 and Resident 104 had VAA reports filed before survey. 2.Actions taken to identify other potential residents having similar occurrences: The facility Vulnerable Adult log and Resident Council minutes from October were reviewed by Administrator. Interviewable residents will be interviewed by for potential VA concerns and non-interviewable resident's weekly skin checks will be viewed to determine injuries of unknown origin and follow-up needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur: Facility Vulnerable Adult policy was reviewed and revised and education on VAA abuse prohibition and reporting requirements was completed with staff and the facility guidelines for VAA reporting online was updated and education was completed with licensed staff by 13 Dec 15. A revised grievance and concern log was implemented on 28 Dec 15 to include "desired outcome". Facility has implemented daily IDT stand	

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F 225	Continued From page 22 R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door and overheard a mans loud voice that was not resident yelling and swearing. Writer was unable to hear what was all being said but did her the word "Fuck", and "your and Asshole" in an angry tone of voice. Writer immediately went into room with nurse and saw resident's family member (FM)-A was yelling at resident. Resident was asked if he wanted FM-A to leave. Resident said yes. FM-A was asked to leave several times by writer before he complied with leaving. FM-A at the time was holding up his phone that had a light and was pointed towards resident. Resident was asked if his FM-A was video taping him. Resident stated yes. Writer asked residnet if FM-A had his permission to do this and resident stated "no". Resident also stated that (FM-A) has, in the past, been physically abusive to him and has also threatened to kill him in the past while at residents home. Resident stated that FM-A had actually pushed him into a bonfire at residents home to try to kill him, and he still had the scars to show for it. Resident express that he didn't know if he wanted FM-A back here at the facility since he has been the only one that has been helping him. Resident also let writer know that FM-A now had keys to his home, truck and was refusing to give those back. FM-A told the resident, "you will have to break into your house if you think you are going back there". Resident also stated FM-A has his laptop and refusing to give that back. The investigation was submitted to the state agency on 7/01/15. During interview 10/26/15, at 6:13 p.m. with the	F 225	up meetings starting 30 Oct 15 to monitor for potential vulnerable adult concerns. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Facility will complete five NAR Care Observations weekly for three months. Facility will complete five Abuse Education Audits of staff; audits will also be completed on grievance log and Resident Council minutes monthly for three months. Facility will monitor VAA reports monthly for three months for timeliness of reporting to the Administrator and state agency. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	

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	245513	A. BUILDING _____ B. WING _____	10/26/2015

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F 225	Continued From page 23	F 225		

DON who stated the incident should have been immediately reported and she did not know why it had been reported late.

Although the incident occurred on 6/26/15, the facility did not report the incident to the administrator and state agency until two days after the incident, on 6/29/2015.

R131's quarterly MDS dated 2/25/15, indicated she was moderately cognitively intact and needed extensive assist of two with transfers.

An Investigative Report dated 4/5/15, indicated that on 4/3/15 R131 had a, "exp. large discolored area to the lateral left breast" which measured 10 cm (centimeter) by 8 cm in size. R131 was reassessed for her ability to continue to be transferred in this type of device, and R131 was determined to require a hoyer lift for transfers. The administrator and the state agency was informed of the incident on 4/5/15 two days later and the investigation was submitted to the state agency on 4/13/15, 10 days after the incident occurred and identified the injury was from a mechanical lift.

During interview 10/22/15, at 2:17 p.m. DON stated the investigation was sent late and didn't know why it was sent late "maybe it was a computer glich". Further, the DON stated because of the size and the location, the incident needed to be reported.

Although the injury was noted on 4/3/15, the facility failed to inform the administrator and and the state agency two days later and the investigation was not reported until 10 days later.

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F 225	Continued From page 24 The facilities Vulnerable Adult Abuse Prohibition Policy and Procedure revised November 2011, indicated "Each employee is responsible to report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The administrator will be notified immediately by on of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy for the timely reporting and investigation of allegations of abuse, neglect, or injuries of unknown origin for 3 of 5 residents (R45, R104, and R131) whose allegations were reviewed.	F 226	F226-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency	12/29/15

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F 226	Continued From page 25 Findings include: A facility Vulnerable Adult Abuse Prohibition Policy and Procedure revised November 2011, indicated, "Each employee is responsible to report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The administrator will be notified immediately by on of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated she was cognitively intact and required assist of two staff with transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously" R45 had "concerns about lift with sling placement and bruising," and, "felt she wasn't taken seriously." The form identified it was given to the DON who responded, "Res [resident] was not feeling well and gets paranoid/depressed with illness ... did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern.	F 226	was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Incident for Resident 45 was submitted on 27 Nov 15 to OHFC. Investigation and follow-up will be completed per regulatory compliance. Resident 131 and Resident 104 had VAA reports filed before survey. 2.Actions taken to identify other potential residents having similar occurrences: The facility Vulnerable Adult log and Resident Council minutes from October were reviewed by Administrator. Interviewable residents will be interviewed by for potential VA concerns and non-interviewable resident's weekly skin checks will be viewed to determine injuries of unknown origin and follow-up needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur:	

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F 226	Continued From page 26 The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any bruising on R45. During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was not investigation done and adminstrator and the state agency were not notified immediately. R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door and overheard a mans loud voice that was not resident yelling and swearing. Writer was unable to hear what was all being said but did her the word "Fuck", and "your and Asshole" in an angry tone of voice. Writer immediately went into room with nurse and saw resident's family member (FM)-A was yelling at resident. Resident was	F 226	Facility Vulnerable Adult policy was reviewed and revised and education on VAA abuse prohibition and reporting requirements was completed with staff and the facility guidelines for VAA reporting online was updated and education was completed with licensed staff by 13 Dec 15. A revised grievance and concern log was implemented on 28 Dec 15 to include “desired outcome”. Facility has implemented daily IDT stand up meetings starting 30 Oct 15 to monitor for potential vulnerable adult concerns. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly for three months. Facility will complete five NAR Care Observations weekly for three months. Facility will complete five Abuse Questionnaire Audits of staff; audits will be completed on grievance log and Resident Council minutes monthly for three months. Facility will monitor VAA reports monthly for three months for timeliness of reporting to the Administrator and state agency. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued.	

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F 226	Continued From page 27 asked if he wanted FM-A to leave. Resident said yes. FM-A was asked to leave several times by writer before he complied with leaving. FM-A at the time was holding up his phone that had a light and was pointed towards resident. Resident was asked if his FM-A was video taping him. Resident stated yes. Writer asked residnet if FM-A had his permission to do this and resident stated "no". Resident also stated that (FM-A) has, in the past, been physically abusive to him and has also threatened to kill him in the past while at residents home. Resident stated that FM-A had actually pushed him into a bonfire at residents home to try to kill him, and he still had the scars to show for it. Resident express that he didn't know if he wanted FM-A back here at the facility since he has been the only one that has been helping him. Resident also let writer know that FM-A now had keys to his home, truck and was refusing to give those back. FM-A told the resident, "you will have to break into your house if you think you are going back there". Resident also stated FM-A has his laptop and refusing to give that back. The investigation was submitted to the state agency on 7/01/15. During interview 10/26/15, at 6:13 p.m. with the DON who stated the incident should have been immediately reported and she did not know why it had been reported late. Although the incident occurred on 6/26/15, the facility did not report the incident to the administrator and state agency until two days after the incident, on 6/29/2015. R131's quarterly MDS dated 2/25/15, indicated she was moderately cognitively intact and needed	F 226	5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	

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F 226	Continued From page 28 extensive assist of two with transfers. An Investigative Report dated 4/5/15, indicated that on 4/3/15 R131 had a, "exp. large discolored area to the lateral left breast" which measured 10 cm (centimeter) by 8 cm in size. R131 was reassessed for her ability to continue to be transferred in this type of device, and R131 was determined to require a hoyer lift for transfers. The administrator and the state agency was informed of the incident on 4/5/15 two days later and investigation was submitted to the state agency on 4/13/15, 10 days after the incident occurred and identified the injury was from a mechanical lift. During interview 10/22/15, at 2:17 p.m. DON stated the investigation was sent late and didn't know why it was sent late "maybe it was a computer glich". Further, the DON stated because of the size and area it was on, she felt it needed to be reported. Although the injury was noted on 4/3/15, the facility failed to inform the administrator and and the state agency two days later and the investigation was not reported until 10 days later. .	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		12/29/15

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F 241	Continued From page 29 by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting aftercares and ensure appropriate incontinence products were provided for 1 of 2 residents (R126) who expressed concerns of undignified care and services. Findings include: R126's admission Minimum Data Set (MDS) dated 9/25/15, identified R126 had intact cognition, required extensive assistance for toileting, and was "always" continent of bowel. R126's care plan dated 10/12/15, identified staff were to provide incontinence products for R126 as needed, and provide assistance from one staff for toileting, bathing and grooming. During interview on 10/20/15, at 3:22 p.m. R126 stated he was dependent on staff for assistance because he was unable to walk or get to his wheelchair by himself, which made him feel anxious and helpless. R126 stated he had waited for up to 30 minutes before to have his call light answered, which only increased his anxiety. R126 reported two instances of having "very close calls" with bowel incontinence because of having to wait for extended periods of time for assistance, and added he still required assistance to complete post toileting care after using the provided bed pan. R126 had a sore on his bottom that would become worse and painful if left on the bed pan too long, so R126 raises himself up from the pan and removes it, the sets himself down on newspaper he places on the bed to keep the linens from becoming soiled until staff could assist him with cleaning. R126 stated he	F 241	F241-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: An interview with resident to obtain preferences completed on Resident 126 on 10 Nov 15 and was offered alternative options of chux, disposable products etc . Resident stated it was his desire to continue use of newspaper to enhance independence, but with improved health condition he did not feel this would be needed any longer. Resident stated with condition improvement he is now using commode at bedside for most all toileting needs. Resident and NAR Care Guide	

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F 241	Continued From page 30 felt this was undignified. R126's family member (FM)-D was present for the interview, and stated R126's statements of lack of toileting aftercare were accurate. On 10/23/15, at 7:03 a.m. R126 stated he had a bowel movement that morning, and again placed newspaper underneath of him when finished utnil staff were able to assist him with clean up. R126 became tearful, and stated, "I just feel so helpless." R126 continued to have visible tears in his eyes, stated he could not continue the interview, and requested the surveyor return later. On 10/26/15, at 10:100 a.m. R126 stated he did not prefer to use newspaper underneath of him while waiting for staff assistance, but added, "That is how I have leaned to work with the system." He did have wetted wipes available, but he was unable to use them due to his mobility impairments, and the only option the staff presented to him versus using newspaper was to wear, "A big diaper." R126 stated he was never offerd a disposable chux (absorbent pads used to collect fluids). Again, R126 became teary eyed during the interview, and expressed frustration and feelings of helplessness, "I have no control over when they are going to come and help." When interviewed on 10/26/15, at 10:27 a.m. nursing assistant (NA)-A stated she had assisted R126 in the past with toileting cares, and seen soiled newspapers on his bed. NA-A stated she had never asked R126 about the soiled newspapers before though, and was unaware he was having to use it as a barrier until staff assisted him. During interview on 10/26/15, at 2:18 p.m. registered nurse (RN)-H stated R126 was always continent of bowel, and a commode at his	F 241	updated to reflect residents preferences for maintaining as much independence as possible. 2.Actions taken to identify other potential residents having similar occurrences: Direct care staff interviewed by 13 Dec 15 and verified Resident 126 is the only resident with this preference. 3.Measures put in place to ensure deficient practice does not recur: Facility policies reviewed and revised as needed related to Resident Rights, Dignity and Toileting. Education will be completed with care staff by 13 Dec 15. MDSs will be completed upon admission, quarterly and with significant change to include a comprehensive bladder assessment. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain	

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F 241	Continued From page 31 bedside had been tried, but R126 tended to prefer the use of a bedpan over a commode. RN-H was unaware R126 was placing newspaper underneath of himself until being assisted by staff with clean up, and added several other products were available and could be used. Further, RN-H stated she expected staff to report it to her if R126 was observed using newspaper in that manner. During interview on 10/26/15, at 5:06 p.m. the director of nursing (DON) stated she was unaware R126 was using newspaper as a barrier to protect his bedding while waiting for staff assistance with clean up, but added it was a "innovative" solution. The DON stated disposable pads were not routinely used in the facility, but they could have been ordered for R126. A letter submitted post survey exit, dated 10/27/15, authored by the DON and signed by the DON and R126 noted, "He [R126] states he uses his trapeze to pull his body up and place himself on the bedpan for a bowel movement, 'I can't reach to clean myself. The cover on the bed is white. I don't want to get it dirty so when I take the pan out I put the newspaper under my butt to keep from getting marks on the blanket. Then I put my light on for someone to come and get the pan and clean me up.' He went on to say that he knows we are busy and he can do some things for himself. As indicated with matching facial expressions and shoulder shrugs [R126] did not indicate that he was bothered or feel that his dignity was being comprised with this innovative self-action." A letter submitted post survey exit, dated 10/28/15, authored by NA-T noted, "A couple of	F 241	compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 241	Continued From page 32 times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put himself on bedpan, notifying staff only when he was done." A letter submitted post survey exit, dated 10/30/15, authored by NA-D noted, "[R126] chose to use newspaper under himself even though I told him he didn't need to do that and we would change linen if it got soiled. He continued to put newspapers under him." A facility policy related to dignified care and services was requested, but was not provided.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for choices. Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, indicated he was cognitively intact, needed assist of two staff with bathing, and it was "very important" to be able to chose the method in which he was bathed.	F 242	F242-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission	12/29/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 33 R73's care plan dated 9/25/15, identified he had been admitted in September 2015, but did not identify any preferences or assistance R73 required with bathing. R73's undated Nursing Assistant Care Sheet indicated he received a tub bath on Thursday by an outside agency. During interview 10/21/15, at 10:02 a.m. R73 stated hospice is to be giving me two baths a week and the facility is supposed to also be giving me two baths a week. R73 then stated, "I have only received two baths from the facility since I have been here." The facilities Mill Creek Bridge Weekly Bath and Vital List dated 9/21/15 to 10/22/15, identified the following: > The week of 9/21/15 to 9/27/15, R73 was not identified on the bath list. > The week of 9/28/15 to 10/4/15, R73 continued to not be identified on the bath list. > The week of 10/5/15 to 10/11/15, R73 was scheduled to receive four baths, but only had one bath documented as being completed. > The week of 10/12/15 to 10/18/15, R73 was again scheduled to receive four baths, but only had one bath documented as being completed. > The week of 10/19/15 to 10/22/15, R73 was scheduled to recieve three baths, but only had two baths documented as being completed. The bath listing identified R7 received two baths from the facility and two baths from the outside agency, a total of 4 out of the 11 baths he should have received. During interview 10/23/15, at 9:15 a.m. nursing assistant (NA)-F stated the staff do the best they can, but added, "We do not have a bath aide and we just can't get all of them done so some of the baths have been missed. That's all I can say." During interview 10/23/15, at 9:21 a.m. registered nurse (RN)-A stated R73 should have received	F 242	against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to honor resident's bathing preferences. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 73 was interviewed for bathing preference on 27 Nov 15 to verify resident preference expressed on 21 Oct 15. Care plan and NAR guides updated to reflect resident preference of baths per week; Hospice will be assisting with resident bathing preferences giving two baths per week and facility providing two. 2.Actions taken to identify other potential residents having similar occurrences: Interviewable Residents were questioned using a modified CMS Resident QIS Interview tool to include bathing preferences and care plans to be updated if needed. 3.Measures put in place to ensure deficient practice does not recur: Facility revised process for interviewing residents about bathing/showering preferences upon admit and with comprehensive RAI reviews. Facility process and procedure for bathing was reviewed and revised. Care staff and Activities educated on change of practice	

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F 242	Continued From page 34 his bath according to his choice adding if it was not documented on the listing, it was not completed. A facility policy on choices was requested, but none was provided.	F 242	with bathing preferences and honoring Resident choices by 13 Dec 15. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 244	F244-E	12/29/15

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F 244	Continued From page 35 facility failed to provide timely follow-up to the resident council groups grievance as concerned with inadequate staffing in the facility. This affected 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. Findings include: During the recertification survey, the resident council minutes were reviewed and identified the following: The resident council minutes dated 7/28/15, indicated under nursing R27, R19, R45, "All feel we do not have enough nursing help due to how long it takes for their call lights to be answered. Writer [activity director (AD)] explained the difference between cutting hours due to census vs. [versus] being short staffed." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R19, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/12/15, from the director of nursing (DON) provided a response which identified, "There are times of the day and night when many residents are requesting assistance at the same time. We are getting to each one of them as quickly as possible we are adequately staffed. Some employees are new and work a little slower while they are learning." The resident council minutes dated 8/13/15, identified, "Updates on last meeting concerns" were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from	F 244	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to provide timely follow-up to resident council groups' grievances and concerns regarding inadequate staffing in the facility. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The Administrator reviewed most recent Resident Council monthly minutes and will report back to Resident Council at the next meeting in December to follow up with action steps the facility is utilizing to address related staffing concerns. R27, R19, R45, R35 and R21 will be invited to the by December Resident Council where follow-up to resident concerns will be addressed. 2.Actions taken to identify other potential residents having similar occurrences: The most recent Resident Council minutes were reviewed by Administrator to	

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F 244	Continued From page 36 the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention too! Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes dated 9/29/15, identified, "Council members are concerned about staffing. Writer [AD] explained staffing. [R21] had concern about waiting to go to his meal for too long. Writer explained about the requirement for a NAR's [nursing assistant, registered] to be able to sit with residents who need assist to eat and that this way likely the reason he had to wait." There was no evidence the repeated concerns regarding inadequate staffing at the facility were addressed by the management team. During interview on 10/23/15, at 12:23 p.m. R45 stated she did not feel the concerns voiced during the council meetings were addressed, adding, "They are so short staffed here at the facility sometimes I have to wait 45 minutes for the staff to help me you see I am immobile and need help to get on the bed pan to have a BM [bowel movement] and when they are late, I can't wait so I have an accident in the bed and that is not pleasant for me." During interview on 10/23/15, at 9:30 a.m. the AD who stated she is in charge of the resident council meetings. AD stated, "The residents do complain about the staffing here and it's a problem everywhere. I let the DON know about their concerns. I always tell them we are trying and with so many residents sometimes you just have to wait."	F 244	identify additional resident complaints and ensured follow up was completed. 3.Measures put in place to ensure deficient practice does not recur: Facility Administrator reviewed and revised Grievance and Complaints policies, and education was provided to Department Heads on 23 Nov 15 on grievances. An update on the annual survey will be presented at the Resident Council meeting in December. 4.Effective implementation of actions will be monitored by: Administrator will review Resident Council minutes to ensure follow up has been completed following every Resident Council meeting for six months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting by the Activity Director, and at that time, the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 244	Continued From page 37 Although R27, R19, R45, R35 and R21 had complaints of staffing on 7/28/15, their concerns continued at the 8/13/15 and 9/29/15 resident council meetings with no objective, measurable plan being identified to resolve there concerns of staffing. The facility Grievances and Complaints policy dated 1/12/12, indicated "it is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." The policy further indicated "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager."	F 244		
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medically related social services needs were identified and provided for 3 of 4 residents (R29, R28 and R56) reviewed for social services. This resulted in actual, psychosocial harm for R28, who expressed fear, inability to sleep, and	F 250	F250-G Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency	12/29/15

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F 250	Continued From page 38 demonstrated signs of distress regarding concerns with her roommate (R29). Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/25/15, indicated the resident had severe cognitive impairment and had dementia with depression. R28's quarterly MDS dated 9/1/15, indicated the resident had severe cognitive impairment, and had dementia with depression. The MDS indicated R28 was depressed, had trouble sleeping, had little or no energy, felt bad about herself, and had trouble concentrating. R28's Care Area Assessment (CAA) dated 6/12/15, indicated the resident received Zoloft, an antidepressant, for diagnosis of depression. R28's care plan dated 9/11/15, indicated she was depressed and was to receive one to one visits to encourage expression of feelings and to, "Explore possible reasons for the resident's distress (e.g., environmental/psychosocial stressors, treatable medical conditions, etc); Implement a mood management plan to compliment drug therapy : sertraline (Zoloft)." The care plan indicated R28 had the potential for abuse from others related to cognitive loss, and the approach was for staff to discuss behavioral issues with the team members as needed, and evaluate the need for psychological referral and evaluation. R28's progress notes reviewed from 7/09/15, to 10/25/15, indicated the following incidents related to R29, who is R28's roomate:	F 250	was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 28 and family were interviewed by Social Service and was moved to a private room on 12 Nov 15. Resident 28 was seen by Associated Psychology and follow up recommendations were added to the care plan. Resident 29 discharged to another facility on 23 Nov 15 to accommodate memory care needs. Family care conference held with Resident 56, spouse, social services, certified dietary manager and corporate dietitians on 18 Nov 15. Diabetic diet reviewed with resident including appropriate snacks available. Resident and spouse were both able to voice back on education they received on carb counting, portions sizes, reading food labels and risks of not following a diabetic	

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F 250	Continued From page 39 On 7/9/15, "Res. [resident] has been crying today. Res. is stating how when she was little her mom used to make her watch the baby and she didn't like it. Res. has also been say that her roommate asks so many questions and needs things and she is getting tired." On 7/15/15, a note documented by activities indicated "Resident is having a hard time with her rooming situation. She says she is not getting much sleep because roommate is up a lot at night talking, delusional as to where she is and accusing resident of things. Resident is crying a lot and is in hopes of changing rooms. Writer consoled resident and said she would see what she could do about the situation." On 8/24/15, resident and roommate had a dispute. R28 stated her roommate yelled at her and she became upset, was crying, and stated she was done dealing with her roommate and wanted a new room. On 8/25/15, a progress note from social services indicated, "Spoke with res regarding incident with roommate last night, res did remember arguing with her roommate. She didn't say she wanted a different room today, but just said that she didn't want to talk to her roommate about just anything, only the weather. Writer validated her feelings letting resident know she doesn't have to talk to roommate about anything she didn't want to." On 9/1/15, "Resident refusing to go into bed as roommate blocking roommate from entering. Resident when in room, 'peeks' into roommates side of room to make sure she is okay." On 9/5/15, resident talked with writer and stated,	F 250	diet. Resident was able to site complications of uncontrolled diabetes that included problems with wounds, eyes, heart, kidneys and vessels. We reviewed healthy snack options and reminded them that facility provides them. Follow up appointment scheduled with diabetic educator in early December. Level II PASRR completed on 11/5/15 and stated that “This person’s medical and health needs are such that he/she requires NF services. This person will be admitted to the NF on 9/10/15” also states “This person’s medical and health care needs are so severe that, in the judgement of the QDDP, the person cannot be expected to benefit from active treatment.” Social Services will continue to work with County Social Worker on clarifying resident’s needs. 2.Actions taken to identify other potential residents having similar occurrences: Social Service reviewed care conferences from past quarter to identify possible additional residents with room-mate concerns with no further action needed. A diagnosis list was run from the facility software to identify other residents with related diagnosis of Developmental Disability or related condition to determine if any other residents met criteria for a level II screening and need for active treatment. 3.Measures put in place to ensure deficient practice does not recur: The facility implemented a daily IDT morning meeting with Social Worker in attendance to discuss social service	

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F 250	Continued From page 40 "I'm loosing my mind, my roommate is rubbing off on me; up at 1 am. Talks of wanting a different room, did leave a message for SW [social worker], 1 on 1 with resident, and was effective at this time." On 9/10/15, resident complaints of not sleeping well last night stating the lady in her room kept her up asking who she is and where she is. On 9/10/15, progress note from social services indicated, "Writer was walking down the hall and res stopped writer and was upset because she stated 'I just saw on TV that I am being taken to court! I have nothing, this is not fair they stole all my money!' When writer asked who stole her money she was not able to say. Res roommate was then coming out of the room and res said 'oh that little bitch! She was screwing with him all night!' Writer let res know that was not nice to call some one names. Writer asked who him was and roommate got closer res said 'oh look here she is she just wants to screw' and she shook her fist at roommate. Writer directed ladies in opposite direction but it took some time for residents to go there separate ways. Res kept stating that 'this is my room' and 'she goes in there all the time and screws him, she is such a little bitch, I cant even eat- I don't even want to look at her." On 9/12/15, resident found in roommates bed and she stated she does this to me all the time. On 9/23/15, resident stated she was up all night with the lady in her room yelling all night. Resident stated she was, "Going crazy." One to one was given. On 9/23/15, "Writer unplugged cord from	F 250	and/or room-mate concerns. Staff educated on overview of PASRR, resident to resident altercation and interventions and resident non-compliance by 13 Dec 15. MDSs will be completed upon admission, quarterly and with significant change to include non-compliance and risk versus benefits. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations weekly times one quarter. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Social Services is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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computer res. stating 'I wish I had one of those' res was asked what? 'That cord for around my neck- I don't sleep cause of that lady in my room.' Res. stated 'I really wont do that but I never get any sleep with her in there.' 1 on 1 was given with relief. SS updated."

On 10/6/15, social service note indicated residents daughter called, "To talk to writer about concerns that resident called her about a man who was after her and her roommate, who was sleeping with all sorts of men and how resident just wanted to commit suicide. Assured Dtr [daughter] that no men were in the building and that res has talked about seeing the men before and they turn out to be not here and roommate does not have men in her bed at night to which [daughter] stated she figured and was not worried about it. She [daughter] was most worried about the suicide comment. [Daughter] is requesting a call from the MD [medical doctor] when he is here on Thursday and Writer let [daughter] know that she would talk to MD as well about res behaviors. Writer then spoke to res about suicidal behaviors and res has no plans to harm herself and is safe at facility. No further action needs to take place today."

On 10/07/15, "Res in confrontation with another Res in hallway this evening. Res was talking about going to 'See my lawyer this week to see what the weather is going to be.' She was also talking about how another res 'needs her ass kicked.' Res eventually calmed down and went into her room. Will continue to monitor."

A Lake Ridge Care Center Fax Update/Order form dated 10/8/15, indicated the MD attempted to call R28's daughter but had the wrong phone

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number and he would call the social worker tomorrow.

On 10/20/15, "Writer informed by NAR (nursing assistant registered) that Res claims roommate said she was going to cut her throat. Res called daughter to inform daughter of situation. Writer asked aides what happened. Aides said roommate didn't want to go in room because Res said she didn't want her there. Then Res made the claim that roommate said she'd cut her throat. Aides said roommate wasn't even around Res to make such a comment. Res and roommate separated at this time. Res on her way back to bed."

On 10/22/15, social service note indicated "Met with resident and discussed comments she made on 10/20/15. Res stated that she did not feel her roommate was going to slit her throat, res stated she felt safe and was not afraid of her roommate. She stated her roommate just wants the whole room that's all and she just gets that way sometimes. Asked res twice if she felt safe with her roommate during the conversation and both times res waved her hands at writer and said oh yes its fine."

On 10/23/15, social service note indicated resident came to writer upset with roommate because of all of her visitors and that she needed to get out of her room because her roommate gets mad at her and shuts the door on her. Because she was so upset writer asked if she felt like hurting herself and res stated, "No, I don't think so."

On 10/23/15, "Resident was up at the front door saying 'I am getting out of here.' Writer told

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resident, Oh it's raining out. You don't want to go out there. Resident replied, I don't care about the rain. I'm not staying here another night; live with these awful people here, I'm leaving. Resident was resistant at first but then writer got resident to go to the Vineyard. Writer reported this info to social services and nursing. At this time nursing put a Wanderguard on resident."

An Associated Clinic of Psychology visit note dated 8/17/15, indicated R28 had depression, and did not have suicidal ideation. The recommendations were to use validation techniques when she appeared to have concerns, or when she voiced concerns.

A Geriatric Services Of Minnesota physician visit dated 9/10/15, indicated, "The patient [R28] did get a bit weepy today while complaining about conflicts with her roommate. I spoke with various staff and apparently the patient has had problems with at least a couple of other roommates and I think she maybe a candidate for a private room." The plan indicated to facility staff, "I will be happy to support a waiver request for a private room."

There was no indication the physician recommendation regarding R28 receiving a private room was followed up on by the facility.

During interview on 10/26/15, at 1:53 p.m. nursing assistant (NA)-T stated R28 and R29 started to have troubles being roommates a few months ago, because R29 gets, "Crazy" in the late afternoon and night time. R29 becomes more confused, and is up hollering during the night. NA-T stated they have come to work in the early morning and R28 would be awake and out of bed crying stating she is fearful of her

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roommate because R29 was, "Making her uncomfortable." R28 had expressed she, "Doesn't like being in that room," and continued to be "unsettled" about having to remain in the room with R29. R28 had ongoing episodes several times a week of not sleeping well at night because of R29, and NA-T stated these concerns were reported to social worker (SW)-A, but SW-A stated she had spoken to R28's family and they didn't want the resident to change rooms, but rather just wanted the facility to add some pictures and music to try to enhance the physical space of the room for R28. NA-T stated one of R28's daughters had recently visited from out of town, and she had expressed desire for R28 to change rooms because she could, "See how it was," between R28 and R29; however, NA-T stated, "Nothing ever got done," about R28 and R29 rooming together.

During interview 10/26/15, at 4:08 p.m. NA-A stated R28 and R29, "Argue all the time, and [R29] is very forgetful; she cant remember five minutes to the next." She forgets what side of the room she is on and they both dig into each others things and it upsets both of them. "[R28] gets upset and will go on a rant that she has no one in her family; she has said she is better off dead but never told me she had a plan. She is not on any suicide checks. We are told there is not enough charting to separate them and the nurses do the charting. It would be nice if they could be separated."

During interview 10/26/15, at 4:13 p.m. licensed practical nurse (LPN)-A stated, "They [R28 and R29] fight a lot. I have asked for a room change and left messages with the social worker. I'm almost ready to give up; we keep charting and

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nothing gets done with it and the staff are very frustrated, they don't ask us about room changes and about what would work best, and who would be compatible with who. I suggested for her [R28] to move to room 126 when that was open because I felt her and the other roommate would be a good fit and they never moved her. [R28] tells me she wants to move.... [R28] says things that she wants to kill herself." LPN-A then stated, "I don't think things are charted as often as they occur." LPN-A stated R28 and R29 just, "Got into it with each other in the hall."

During interview 10/26/15, at 4:23 p.m. R28 stated, "I have never been treated like this ever in my life." R28 started to cry, and LPN-A (who was present at the time of interview) gave her a Kleenex. R28 stated, "I have asked for a different room, I want a different room, and I have told the gals that work here that!" R28 continued to cry wiping her tears with her Kleenex. R28 then began rubbing her head and stated, "Oh my god I am so tired of this, I have it in the back of my mind to end my life. I am 86 years old, why do I have to put up with this?" R28 stated her roommate (R29), "Is nastier than nasty." At 4:33 p.m., R28 was still crying.

During interview on 10/26/15, at 4:36 p.m. social worker (SW)-A stated everyone at the facility was aware R28 and R29 did not get along. SW-A stated she and the director of nursing (DON) had discussed moving the residents to separate rooms, but felt it would not be a benefit to move either one of them. SW-A stated R28 hallucinates and had made comments about a man being in the room when there hasn't been a man around. SW-A stated she was not aware if R29 was keeping R28 up at night, and stated she

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had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty rooms all have roommates, and the facility felt they would rather wait for a private room to open before moving R28. SW-A stated she had not filled out a waiver for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated R28 had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 8/17/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here."

During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken to her about moving R28 to a different or private room.

During interview 10/26/15, at 6:03 p.m. DON stated a lot of the staff know there, "Is a clash between [R28] and [R29]." The DON stated she was not aware where the social worker was at with the situation between the resident, and the SW made the determination regarding resident room assignments, however, the DON stated, "I

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am not sure why they haven't moved one of them." DON stated she heard about suicidal comments from R28, but was not aware R28 made a comment about wanting a cord for around her neck, and stated, "If she [R28] said that, she had a plan."

R56's undated Resident Admission Record identified diagnoses including diabetes mellitus, bipolar, anxiety, depression and other specified mental disorders due to known physiological condition.

R56's Initial Pre-Admission Screening (PAS) Results based on information submitted on 9/9/15, by the Buffalo Hospital social worker SW-C, identified she had a diagnosis of mild intellectual disabilities. The screening noted, "Based on the information provided for this nursing home stay, it appears this person meets the criteria for DD [developmental disability] and needs to be referred to the lead agency for further evaluation. Please note final determination of the need for referral for further evaluation will be made by Senior LinkAge Line ®." A PASRR level 1 screening dated 9/10/15, completed by R56's Wright County case manager/ SW-D declared R56 did not have a developmental disability or related condition (DD/RC), had never been considered to have DD/RC, had no presenting evidence that might have indicated the presence of DD/RC, and had not been referred for nursing or boarding care facility placement by an agency that served persons with DD/RCs. However, an additional PASRR level 1 screening dated 9/11/15, was maintained as part of R56's medical record. This screening was completed by registered nurse (RN)-F, with no associated agency identified on the forms. This screening

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declared R56 did have a DD/RC and presenting evidence was present that may have indicated the presence of DD/RC. Though conditions were identified, no referral was made for completion of a PASRR level 2 evaluation. The facility did not pursue clarification of these conflicting screenings, to ensure R56 received the appropriate supports.

Her admission MDS dated 9/17/15, identified her cognition was intact and required extensive assistance for most activities of daily living (ADLs), but required only supervision and set up for eating. The MDS identified R56 was on a therapeutic diet and received insulin medications

The CAA dated 9/17/15 noted,"[R56] is needing assistance with all ADLs following hospitalization for hypoglycemia. Needs encouragement from staff to participate. Discharge plan is uncertain. She maybe looking at moving to a group home or foster home. Husband is having difficulty caring for her." The CAA noted R56 was on a therapeutic diet related to her diagnosis of diabetes. The CAA noted, "Resident tolerates diet well with good intakes and good glucose levels."

R56's care plan dated 10/22/15, directed staff to provide her with a diabetic diet of mechanical soft texture. The care plan directed R56 was to receive supervision and set up for eating. The care plan did not further address R56's diet, direct interventions to support R56 in management of her diabetes, direct interventions to support R56 in relation to her intellectual disability, or direct coordination of care between the facility and R56's county case manager.

Her physician orders dated 10/23/15, directed the

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F 250	Continued From page 49 following: GlucaGen 1 milligram (mg); intramuscular injection; one dose as needed for severe low blood glucose when R56 was unable to take sugar by mouth, started on 10/2/15. Lantus 100 units/ milliliter (mL) 30 units; subcutaneously injecting once daily at bedtime, for diabetes, with dosing adjusted on 10/23/15. Novolog 100 units/mL 6 units; subcutaneously injecting before breakfast, before lunch and before supper and holding if R56's blood glucose was less than 150, for diabetes, with dosing adjusted on 10/23/15. Novolog Flexpen 100 units/mL sliding scale (200-250 = 3 units, 251-300 = 5 units, 301-350 = 8 units, 351-400 = 10 units, >400 = 12 units); subjutaneously injecting before breakfast, before lunch and before supper, for diabetes, with dosing adjusted on 10/23/15. Accucheck (blood glucose monitoring) at 3:00 a.m., 7:00 a.m., 11:00 a.m., 4:00 p.m. and 7:00 p.m. daily, ordered on 10/23/15. Diabetic diet with mechanical soft textured food, with an order date of 10/2/15. "Very important for patient to be on a diabetic diet. All junk food should be removed from patient's room." The order start date for this directive was 10/14/15. Review of R56's Vitals Report from 9/10/15, through 10/26/15, identified her blood glucose levels were unstable, with extreme highs and extreme lows. Blood glucose readings under 50 mg/ deciliter (dL) and over 500 mg/dL included the following: 9/12/15 (45 mg/dL), 9/15/15 (44 mg/dL), 9/16/15 (45 mg/dL), 9/24/15 (44 mg/dL), 9/27/15 (572 mg/dL), 10/2/15 (586 mg/dL), 10/7/15 (554 mg/dL), 10/8/15 (539 mg/dL), 10/20/15 (48	F 250		

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F 250	Continued From page 50 mg/dL), and 10/23/15 (24 mg/dL), and 10/25/15 (532 mg/dL). Review of progress notes from 9/10/15, through 10/26/15, included the following evidence of education provided to R56 in relation to her diabetic diet and/or concerns of noncompliance with her diet: On 9/15/15, at 8:25 p.m. LPN-D noted, "... noncompliant with [diabetic] diet; spouse in to visit with resident this evening; brought in PB [peanut butter] sandwich, 2 [two] bags chips and soda for resident all of which she ate for HS [bedtime] snack." On 9/16/15, at 4:21 p.m. registered nurse (RN)-C noted, "[R56] would like to talk with the dietician regarding her meals. Message left with manager." On 9/17/15, at 9:13 a.m. certified dietary manager (CDM)-A noted, "Sat down with resident at breakfast and discussed her diet. Resident was unsure of what she was supposed to eat and how to order on a diabetic diet. We talked about 4-5 carbs [four to five carbohydrate choices] a meal and to go for healthy carbs like fruits vs [verses] the chips and pop. We spoke about sugars and I gave her some reading materials on diabetes. I also gave her a mini meal cheat sheet to help her order and still be in her carb count." On 9/17/15, at 9:15 a.m. CDM-A noted her initial nutritional assessment for R56. The assessment included, "Resident is currently on a Diabetic diet. She is independent with eating once a staff member has set her up. Her intakes are 76-100%. She is independent with her ordering and has been counseled as to how many carbs to have per meal and to watch her sugar intake. Also for HS snacks to try to have a half sandwich and small milk. She has been having a hard time with her choices for snack... Will provide diet per	F 250		

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F 250	Continued From page 51 order and monitor weights and intakes for changes." On 9/21/15, at 12:00 a.m. LPN-I noted, "Appears noncompliant with diet ie: drinking large coke and numerous snack wrappers in trash. Encouraged... to not drink coke as that might be causing hi BS [high blood sugars]. Verbalized understanding and then proceeded to drink coke." On 9/23/15, at 11:12 a.m. LPN-F noted, "Resident is not compliant with dietary needs. Although resident does usually choose to eat sugar free items, resident eats a lot of carbs... Resident has a large amount of sugar free candies in her room." On 10/13/15, at 10:42 a.m. LPN-F noted, "Resident has been snacking on chips today et [and] yesterday morning et afternoon." On 10/15/15, at 5:24 p.m. LPN-J noted, "Resident left facility again to go out to eat with her husband to KFC and will r/t [return] later tonight." On 10/21/15, at 2:07 p.m. LPN-F noted, "Resident has been provided reminders of appropriate meal selections for snacking." On 10/22/15 at 1:20 p.m. LPN-F noted, "Resident's husband here et took resident out at lunchtime." On 10/22/15, at 11:05 p.m. LPN-D noted, "Resident noncompliant with DM [diabetic] diet. Has variety high carb, high sweets in room; reviewed diabetic choices; resident stated 'ya, but I like these.'" On 10/23/15, at 123:32 p.m. RN-H noted, "Appetite is good; continues to snack frequently on high carb snack food. Was seen today by [primary medical doctor], and counseled about diet." On 10/24/15, at 8:48 a.m. LPN-J noted, "Continue to educate on her diabetes and food choices."	F 250		

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During interview on 10/23/15, at 7:33 a.m. RN-H reported R56 had a seizure earlier that morning, prompted by hypoglycemia. She stated, though R56 had not had a seizure since admitted to the facility, she did have a history of this occurring when she lived at home. RN-H reported a seizure from hypoglycemia was what had resulted in the hospitalization just prior to her admission to this facility. RN-H stated R56's blood sugars were extremely erratic and that they wient way high, then way low. She said that R56 was non-compliant with her diet and this had been a longstanding issue from prior to her admission. She stated facility staff talked with her frequently about her diet and educated her on what she should or should not have been eating, but they had to honor her right when she declined to let them take snacks out of her room. RN-H stated R56's husband was bringing lots of snacks in for her. She added, facility staff tried to educate him all of the time, with no success.

During interview on 10/23/15, at 12:38 p.m. nurse practitioner (NP)-B expressed concerns regarding R56's diet non-compliance. When asked whether R56 had the capacity to make an informed decision about her diet he responded, "No. And that is why we are trying our best to get her in a group home." NP-B added, he and R56's primary medical doctor had a meeting the week prior, with the Wright County case manager/ social worker SW-D, who was assigned to R56's case. The discussed discharge planning options for R56 as she was scheduled to discharge from the facility the following week. He stated, SW-D wanted to allow R56 to return home, with additional in-home services. However, he stated, "Last time [they] tried that, she turns them away, tells them to

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leave and go home." NP-B stated R56 historically did not allow in-home service providers to actually provide the support necessary. NP-B reported, "Really the only way to get her to follow her diet would be to commit her." He stated R56's husband, also did not have the capacity to make decisions on her behalf. He stated he was unsure of whether SW-D was pursuing guardianship at this time. NP-B stated he and R56's primary medical doctor were working very hard to find a working plan. NP-B stated the facility staff needed to honor R56's choice if she would not allow them to remove the snacks from her room. He stated he was not surprised to learn snacks of chips and soda pop were observed in her resident room throughout the week.

During observation and interview on 10/23/15, at 1:00 p.m. R56 denied facility staff had talked with her about how to make meal selections within the confines of her diet. However, she stated they did talk to her about what kind of snacks to choose. She stated they told her to eat peanut butter with bread and fruit. R56 stated she would have allowed the staff to remove snacks from her room if they wanted to. She denied having been asked if they could remove snacks from her room. R56 stated she knew how to make food selections in compliance with her diabetic diet. She stated she ate what she wanted to eat and routinely went out to eat with her husband. Several snack-sized potato chip bags were observed on a chair in R56's resident room. Each of the bags were opened, with approximately half of the contents remaining. R56 affirmed her husband routinely brought snacks into the facility for her.

During interview on 10/26/15, at 9:06 a.m. SW-A sated she had noted R56 as potentially requiring

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a PASRR level 2 when she did her pre-admission screening before she was accepted as a new admission, "but then she ended up coming across as not being a level 2." SW-A stated Senior LinkAge Line ® typically contacted the facility when a level 2 evaluation was required, then a county worker typically came out to the facility to complete the level 2 screening. SW-A reported she did not know if it was the facility's responsibility to follow-up if the county did not come out. When asked whether R56 had a diagnosis of developmental disability, SW-A stated she did not see any diagnoses in her medical record to support this. She stated the hospital told her R56's county case manager was very involved and there was discussion of potential placement at a group home. SW-A stated, "If you talk with her and are around her it seems like there would be a DD diagnosis." SW-A confirmed she was not involved in assisting R56 with her diabetes management or compliance with her diet. She had provided no consultation with regard to adaptations for education materials or approaches to enhance R56's comprehension of her dietary needs. At the time of interview, SW-A was handed a large bag of chips from another facility employee. She stated it was 'contraband' from a resident who was not supposed to eat that type of food. She stated that it was part of that resident's plan, for staff to check his room for contraband and remove anything found. When asked whether there had been any consideration for a similar arrangement to be made for R56, SW-A stated that the other resident had cognitive disabilities which limited his ability to make appropriate diet choice, but R56 did not have any such diagnosis and therefore, she did not have the authority to implement such a plan. SW-A confirmed she had

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not coordinated with the county case manager to identify any social service needs for R56.

During a telephone interview on 10/26/15, at 9:41 a.m. SW-D stated R56 had received in-home services from an independent living skills (ILS) provider who tried over the past year to help R56 develop a calendar or book to track what she was eating. SW-D stated the ILS services had not proved successful and that R56 did not appear to have the capacity to comprehend the risks associated with failing to comply with her diabetic diet. SW-D stated she did believe R56 required specialized support to work with her on compliance with her diet. She reported R56 "definitely" required more one-on-one attention and the county was currently considering the pursuance of legal guardianship. When asked about R56's diagnoses, SW-D stated there was some indication of a learning disability, but she did not see anything in her record identifying an actual diagnosis of developmental disability. However, as the conversation progressed, SW-D mentioned some psychological testing that was completed for R56 approximately six months prior. Upon further inquiry, SW-D stated the testing identified an intelligence quotient (IQ) of 63 and included a notation of moderate intellectual disability. A Psychological Interpretive Report signed 3/25/15, detailed assessment and psychological testing that was completed on R56 at Nystrom & Associates, Ltd by licensed psychologist (LP)-A. The report detailed R56 had a Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), full scale IQ of 63, with a resulting diagnosis of moderate intellectual disability.

During interview on 10/26/15, at 1:59 p.m. RN-H

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stated R56 had a long history of fluctuating blood sugars. She stated, on 10/23/15, when R56 had a hypoglycemic event, the police and paramedics who arrived at the scene were familiar with R56 and had indicated a history of responses to similar calls when R56 lived at home. RN-H stated facility staff had done education with R56 and her husband regarding her snacks. However, she added, "...as of right now she is her own person and she can make those decisions." When asked whether R56 had the ability to understand the risks of non-compliance with her diet, RN-H stated, "Hard one to answer... because the only real diagnosis we have is the bipolar disease... I think there is some cognitive impairments with her... Maybe a group home or foster home would be a better option, but guardianship is not in place yet." RN-H was asked what adaptations, if any, had been made to the verbal education and education materials provided to R56, to optimize her understanding. She replied she was unsure whether any adaptations had been made. However, she added, "Mainly it is more the staff reminding her... When it's snack time she does have a sandwich and dietary is involved at meal times. When dietary staff take her order they can make recommendations on healthier options."

During interview on 10/26/15, at 4:56 p.m. the DON stated the facility's social service department was responsible for overseeing the PASRR process. She stated she did not believe there was anyone in the facility who required a PASRR level 2. She stated she was not aware R56 had a diagnosis of intellectual disability. She stated, "If I had known... yes, we would try to work with her where she is at." The DON reported she was unsure whether facility staff had made any

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F 250	Continued From page 57 adaptations or provided any kind of specialized support to R56 with regards to her diet. She added, "Her diabetes is so significant, she has some needs that I think are a little different... we do what we can to identify them... I would expect the social worker to be coordinating that [any specialized supports] and then nursing interjected into that." A facility policy addressing the responsibilities of social services was requested, but was not provided.	F 250		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance with personal hygiene, including brushing his teeth. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room, and showed he had several missing teeth on his	F 282	F282-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.	12/29/15

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F 282	Continued From page 58 upper palate when asked about his oral health. R5's care plan dated 7/14/15, identified R5 had an, "Alteration in ADLs [activities of daily living] of dressing, grooming and bathing...". Further, the care plan directed staff to assist R5 with, "Oral care am [morning] and pm [evening]..." During interview on 10/23/15, at 12:55 p.m. NA-F stated the care plan is used to know "what we're [staff] supposed to do" for the residents care. NA-F helped R5 get ready for the day, but did not offer or assist him to complete oral cares. Further, NA-F stated she should make sure R5 is having his teeth brushed and cleaned so R5 doesn't develop oral disease, or loose additional teeth. When interviewed on 10/23/15, at 1:04 p.m. RN-A stated R5 needs to be set up with assistance to complete oral cares, and NA-F should have offered his oral cares, "That's what should be happening." A facility policy regarding care plan implementation was requested, but was not provided.	F 282	It is the policy of Lake Ridge Care Center to provide oral cares as directed by the plan of care. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 5 was interviewed for preferences related to oral care on 30 Oct 15 and care plan/NAR Care guide updated. Oral care audits on Resident 5 will be completed periodically as facility does NAR Care Audits to ensure oral cares delivered according to care plan. 2.Actions taken to identify other potential residents having similar occurrences: Residents identified as having potential to be affected by area cited are residents who require assist with oral cares. 3.Measures put in place to ensure deficient practice does not recur: Education provided to care related staff by 13 Dec 15 providing oral care and following resident care plans. Resident Care plans and NAR care guides will be updated to reflect resident oral care needs. MDSs will be completed upon admission, quarterly and with significant change to include oral care needs. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable	

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F 282	Continued From page 59	F 282	Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(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 condition of the individual, the individual requires the level of services provided by a nursing facility;	F 285		12/29/15

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F 285	Continued From page 60 and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation 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 mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) level 2 evaluation was completed for 1 of 1 resident (R56) with a diagnosis of moderate intellectual disability. Findings include: R56's undated Resident Admission Record identified a diagnosis of other specified mental	F 285	F285-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents	

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F 285	Continued From page 61 disorder due to known physiological condition. R56's Initial Pre-Admission Screening (PAS) Results based on information submitted on 9/9/15, by the Buffalo Hospital social worker (SW)-C, identified she had a diagnosis of mild intellectual disabilities. The screening noted, "Based on the information provided for this nursing home stay, it appears this person meets the criteria for DD [developmental disability] and needs to be referred to the lead agency for further evaluation. Please note final determination of the need for referral for further evaluation will be made by Senior LinkAge Line ®." A Fax Transmittal Sheet dated 9/10/15, sent to the facility social worker (SW)-A from Central MN Council on Aging/ Senior LinkAge Line ®, noted R56's PAS was forwarded to Wright County for processing, as per the process for residents identified on a home and community based services (HCBS)- waiver. A PASRR level 1 screening dated 9/10/15, completed by R56's Wright County case manager declared R56 did not have a developmental disability or related condition (DD/RC), had never been considered to have DD/RC, had no presenting evidence that might have indicated the presence of DD/RC, and had not been referred for nursing or boarding care facility placement by an agency that served persons with DD/RCs. Since none of these conditions were identified, no referral was made for completion of a PASRR level 2 evaluation. An additional PASRR level 1 screening dated 9/11/15, was maintained as part of R56's medical record. This screening was completed by	F 285	or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure PASRR evaluations are completed with a diagnosis of moderate intellectual disability. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The facility received a Level II Preadmission Screening from Irina Steuven, Wright County Social worker on 5 Nov 15. 2.Actions taken to identify other potential residents having similar occurrences: A diagnosis list was run from the facility software to identify other residents with related dx of Mental Retardation or Mental Illness to determine if any other residents met criteria for a level II screening. 3.Measures put in place to ensure deficient practice does not recur: Social Worker, or their designee, has been educated on PASRR and will be reviewing Senior LinkAge Line PAS forms for notation that resident may have DD or Mental Illness. Social Worker or designee will compare Senior LinkAge Line PAS, Level I and resident diagnosis for pertinent diagnosis that would indicate the need for a Level II. Social Worker is responsible to attach Preadmission Screening to resident electronic medical	

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F 285	Continued From page 62 registered nurse (RN)-F, with no associated agency identified on the forms. This screening declared R56 did have a DD/RC and presenting evidence was present that may have indicated the presence of DD/RC. Though conditions were identified, no referral was made for completion of a PASRR level 2 evaluation. During interview on 10/26/15, at 9:06 a.m. SW-A stated she had noted R56 as potentially requiring a PASRR level 2 when she did her pre-admission screening before she was accepted as a new admission. SW-A stated Senior LinkAge Line ® typically contacted the facility when a level 2 evaluation was required, then a county worker typically came out to the facility to complete the level 2 screening. SW-A reported she did not know if it was the facility's responsibility to follow-up if the county did not come out. When asked whether R56 had a DD/RC diagnosis, SW-A stated she did not see any diagnoses in her medical record to support this. She stated the hospital told her R56's county case manager was very involved and there was a discussion of potential placement at a group home. SW-A stated, "If you talk with her and are around her it seems like there would be a DD diagnosis." During a telephone interview on 10/26/15, at 9:41 a.m. SW-D stated she had worked with R56 for over a year and a half. SW-D reported R56 "definitely" required more one-on-one attention and the county was currently considering the pursuance of legal guardianship. When asked about R56's DD/RC diagnoses, SW-D stated there was some indication of a learning disability, but she did not see anything in her record identifying an actual DD diagnosis. However, as the conversation progressed, SW-D mentioned	F 285	record. 4.Effective implementation of actions will be monitored by: The facility will audit five residents' charts per month for three months, comparing Senior LinkAge Line PAS, PASRR and diagnosis list to determine if Pre-admission screening Level II was completed as required. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Social Worker is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 285	Continued From page 63 some psychological testing that was completed for R56 approximately six months prior. Upon further inquiry, SW-D stated the testing identified an intelligence quotient (IQ) of 63 and included a notation of moderate intellectual disability. Review of a Psychological Interpretive Report signed 3/25/15, detailed assessment and psychological testing that was completed on R56 at Nystrom & Associates, Ltd by licensed psychologist (LP)-A. The report detailed R56 had a Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), full scale IQ of 63, with a resulting diagnosis of moderate intellectual disability. Although R56 had two separate PASRR screening completed by two different individuals, the facility did not contact the county agency to clarify the discrepancy between the two PASRR, to determine if R56 needed a level 2 PASRR screen completed. A facility policy regarding PASRR screenings was requested, but was not provided.	F 285		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		12/29/15

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F 309	Continued From page 64 by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce pain for 1 of 3 residents (R118) reviewed for pain. R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change which resulted in actual harm. The facility also failed to provide proper wheelchair positioning for 1 of 1 residents (R57) who was leaning significantly to the right side. Findings include: PAIN: R118's undated Resident Admission Record identified diagnoses including peripheral vascular disease (PVD), osteoarthritis in right hip, cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg non-healing with an infection, chronic pain syndrome, and Trigeminal Neuralgia (nerve pain). The admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and she required limited assistance for most activities of daily living (ADLs). The MDS identified R118 did not receive scheduled pain medication, but received as needed (PRN) pain medication and non-pharmacological interventions for pain management. The MDS identified the pain made it difficult to sleep at night, and limed her day to day activity. A self-reported numerical pain rating scale identified her current pain was a nine out of 10 (a zero (0) to 10, numeric pain rating scale of 0 = no pain, 10 = the most intense pain imaginable). Her pain was identified as frequent, but did not include a	F 309	F309-G Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure residents receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 118 had comprehensive pain assessment completed, and medical provider was contacted multiple times for changes in pain management. Resident was hospitalized on 17 Nov 15 for wound assessment and treatment. Upon return from the hospital, a pain assessment was completed and Care Plan was updated to reflect resident pain goals and individualized interventions. Resident 57 had Occupational Therapy, evaluation completed for positioning with	

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F 309	Continued From page 65 verbal description of the pain even though the MDS identified she had one arterial or venous ulcer at the time of the MDS. The Care Area Assessment (CAA) dated 8/24/15, identified R118 needed assistance with all ADLs due to weakness and decreased mobility from osteoarthritis, but wanted to do as much for herself as possible. The CAA identified R118 had a stasis ulcer on her right leg that was infected and continued to drain large amounts of fluid. The CAA identified R118, "Is complaining of pain due to neuropathy, osteoarthritis, and stasis ulcer on right lower leg. States that PRN Tramadol [Ultram, an analgesic medication] relieves pain. Also uses warm towels and repositioning. Staff will continue to monitor for pain and update MD [medical doctor] as needed." Although the MDS identified R118 had pain, which made it difficult to sleep, and limited her day to day activity, the facility had not assessed this area to determine if the pain regime was appropriate for R118. The care plan dated 10/9/15, identified R118 was at risk for uncontrolled pain related to osteoarthritis and stasis ulcer to her right lower extremity. The care plan goal was for R118 to state her pain was decreased with the use of an analgesic, or show non-verbal signs of decreased pain. Interventions included the following: ·Encourage R118 to report pain levels PRN, per a numeric scale as able. ·Administer medications to R118, routine and PRN, as ordered for pain. ·Monitor R118 for changes in comfort PRN, reassessing her pain as needed. ·Offer R118 comfort measures PRN, of repositioning, heat, cold, massage, diversional	F 309	changes to plan of care with a follow up Occupational Therapy evaluation for adaptations for comfort and skin. 2.Actions taken to identify other potential residents having similar occurrences: All residents have the potential for pain. All residents with identified pain will have their assessment and pain management reviewed, to ensure they have proper pain control. All residents in wheelchairs will be observed for proper positioning. 3.Measures put in place to ensure deficient practice does not recur: Staff will be educated on pain identification and management and licensed nurses will be educated on the Pain Observation by 13 Dec 15. Residents will be routinely assessed for pain using the eMAR system. MDSs will be completed upon admission, quarterly and with significant changes to include a comprehensive pain assessment. Care staff will be educated on wheel chair positioning and follow-up by 13 Dec 15. Facility has implemented daily IDT stand up meetings starting 30 Dec 15 to monitor for potential residents with pain and w/c positioning concerns. 4.Effective implementation of actions will be monitored by: Facility will complete five NAR Care Observations weekly and facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations	

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F 309	Continued From page 66 activities, etc... During observation and interview on 10/21/15, at 11:30 a.m. R118 complained of unmanaged pain related to an open sore to her right, lower leg. She stated a routine dressing change had just been completed to her right leg and reported the pain she experienced during these dressing changes was excessive, stating her pain "hits over a 10." R118 stated if the nurses think of giving her pain medication before and after the dressing change they will, along with some ice. The ice packs, and pain medication at times, "Will subside almost, and then all of the sudden it is like a grabbing pain that almost sends me through the ceiling." During this conversation, R118 was frequently rubbing her right, lower leg and applying ice packs to the area. R118 stated her current pain level was,"down to a five [5] ... it is tolerable." R118 reported a pain rating of 5 was an acceptable level of pain for her. On 10/22/15, at 9:28 a.m. R118 was observed in her room, receiving her morning medications from licensed practical nurse (LPN)-F. Both LPN-F and R118 confirmed she had just received a pain medication (Gabapentin 300 mg, pain medication to treat nerve pain) and she typically liked to wait "for her pain pill to kick in," before her dressing change was completed. R118 asked LPN-F to return in a half hour to complete her dressing change and to bring an ice pack. At 10:01 a.m., R118 stated, "[Her pain medication] never quite cuts it... when they start scraping, there's nothing [that could stop the pain]." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never	F 309	weekly for three months. Ten chart audits will be done monthly for three months for pain management. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	

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does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m. LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, it's starting to burn." LPN-F asked R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the

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stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated, "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118.

During interview on 10/22/15, at 10:51 a.m. LPN-F confirmed the verbal and non-verbal pain indicators she observed, which was a typical reaction during her dressing changes. LPN-F reported R118's doctor and nurse practitioner were aware of these symptoms. LPN-F stated R118's pain management regimen consisted of offering Ultram first, then oxycodone if the Ultram was not effective. LPN-F added, she could also have ice at any time and this has been the same pain management regimen for R118 for some time. She was not sure what the rational of the physician was, for not making further changes to the pain medicaiton regimen. LPN-F stated, She trys to give her (R118) time when she removed the dressing, so she (R118) can take a breath and "get her bearings" and will then continue when she is ready.

R118's current physician orders dated 10/26/15,

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F 309	Continued From page 69 directed the following wound treatment and pain management regimen: ·Wound treatment to stasis ulceration on right lower extremity- cleanse wound, apply Silversorb, cover with ABD pad and Kerlix, change dressing daily and PRN. ·Gabapentin 300 milligrams (mg), twice daily for peripheral neuropathy/ polyneuropathy. ·Ultram 50 mg, every four hours PRN for pain, for chronic pain syndrome. ·Oxycodone 5 mg, every four hours PRN for pain not relieved by Ultram, for chronic pain syndrome. Review of R118's physician progress notes from 8/17/15, to 10/26/15, identified the following: R118's New Patient History and Physical Examination, completed by medical doctor (MD)-A and dated 9/3/15, noted she had osteoarthritis affecting her knees, shoulder and hip, with residual pain post knee and hip arthroplasties. The report did not further address her pain. On 8/24/15, nurse practitioner (NP)-A noted R118 had complaints of pain to her right lower extremity with dressing changes. On 9/10/15, NP-A noted the appearance of R118's right lower leg and reviewed the dressing treatments. NP-A noted, "Discussed pain control will add oxycodone for mod [moderate]/severe pain." On 9/23/15, a Wound Care/ Hyperbaric Medicine History and Physical noted, "There is a wound on the anteromedial portion of [R118's] right lower leg. This measures 11 x [by] 12.5 x 0.1 cm [centimeters]. The wound is about 60% yellow fibrin and 40% pale red. It is very tender to touch and I am unable to do any sort of debridment on it. It does not appear to be infected... I initially tried to dress the patient's wound with Medihoney;	F 309		

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however, the patient developed a lot of discomfort with this. My initial inclination had been to treat it with lodosorb in an attempt to control drainage but the patient was afraid that that would be painful... She did receive a dose of oxycodone here and once her pain got better her wound was then dressed..."
On 10/8/15, NP-A addressed R118's chronic right lower leg ulcer. NP-A noted, "Resident today says, 'I'm ok,' but frowning and awaiting R [right] LE [lower extremity] dressing [change]. C/o [Complains of] pain to R LE. Refuses to go back to Monticello Wound Clinic- 'They don't know nothing.' She is very particular about what she will allow to be put on R LE wound... looks unhappy- waiting for dressing [change]." The note directed no change to the wound treatment and to continue with antibiotic treatment for cellulitis through 10/12/15.
On 10/19/15, NP-A noted R118's emergency room visit was reviewed. The note did not address R118's stasis ulcer.
No further assessment, description, or plan for pain management were included in the physician progress notes.

Review of R118's Electronic Medication Administration Record (EMAR) from 9/1/15, to 10/25/15, identified the following as PRN pain medications were administered for right, lower extremity and leg pain.

The September 2015 EMAR identified R118 took a total of 103 doses of PRN pain medication. She took 68 doses of Ultram 50mg, which were effective 42 of 68 opportunities; slightly effective 14 of 68; not effective 2 of 68, and other, which was not identified for 1 of 68 opportunities.

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R118 had 35 doses of PRN oxycodone 5mg in September 2015, which was effective 14 out of 35 opportunities; slightly effective 3 out of 35; and other which was not identified 3 out of 35, opportunities.

The October 2015 EMAR identified R118 was administered 100 doses of pain medication for right, lower extremity leg pain. She took 49 doses of Ultram 50mg, which was effective 18 out of 49 opportunities; slightly effective 17 out of 49; and not effective 6 out of 49 opportunities.

R118 had 51 doses of PRN oxycodone 5mg, in October 2015 which was effective 34 out of 51 opportunities; slightly effective 11 out of 51; not effective 5 out of 51 and other, which was not identified, 1 out of 51 opportunities.

Review of the EMAR PRN administration times from September to October 2015, did not correlate with R118's dressing changes, because the dressing changes were not consistently documented.

Even though R118 was administered 203 doses of PRN pain medication, taken in 55 days, approximately 3.7 doses of PRN pain medication each day, along with her scheduled Gabapentin 300 mg twice a day. R118 continued to experience significant pain with her dressing changes.

Review of R118's nursing progress notes from 8/17/15, through 10/26/15, identified complaints of pain for R118:
On 8/24/15, at 10:18 p.m. LPN-G noted, "Changed dressing on lower right leg ... About an hour later Resident had c/o a 'burning pain.'

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F 309	Continued From page 72 Writer asked if a pain pill would help or if it was too much and it needed to be taken off? Resident asked for it to be taken off. Writer took off dressing... cleaned wound and only applied Bacitracin with non-stick dressing then covered with ABD and wrapped with Kerlix. Resident has not have any further c/o pain but is requesting that she receive something else on the wound that won't burn." On 8/27/15, at 1:09 a.m. LPN-D noted, "[R118] rates pain 8/10; ...per resident alginate dressing 'burns' refused to have on skin; ...communication being sent to update PMD [primary medical doctor]." On 8/27/15, at 10:23 a.m. LPN-F noted, "Leg dressing changed... Area continues to be red, macerated et [and] tender to the touch... Resident claims the wound spray hurts her when use for washing wound. Resident refused it to be used on her D/T [due to] reported pain." On 9/6/15, at 10:48 p.m. LPN-D noted, "[R118] c/o pain in RLE... dressing removed per [R118's] request; cool cloth applied with some relief; leg has been elevated; will reassess in one hour when may have prn pain medication." On 9/7/15, at 1:39 p.m. registered nurse (RN)-C noted, "[R118] refused to have dressing put on in fear that it would start hurting again... [R118] is leaving it open to air. PRN given." On 9/8/15, 2:28 p.m. LPN-B noted, "Writer called the on call MD/NP and left a message regarding resident's wound on her leg. Resident is refusing to let staff place a dressing on her leg per orders." On 9/8/15, 11:10 p.m. LPN-C noted, "[R118] c/o pain to RLE. [R118] is unable to have any more prn pain medication for another 2 [two] hours. On call physician... said to use standing order of Tylenol. Will administer Tylenol and continue to	F 309		

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F 309	Continued From page 73 monitor." On 9/13/15, at 12:25 p.m. LPN-B noted, "... [R118] does c/o pain during a.m. dressing change... PRN pain medication given x [times] 2 at this time." On 9/19/15, at 1:12 a.m. LPN- D noted, "[R118] c/o 7/10 pain right lower extremity; somewhat relieved with prn Tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]." On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, 'It burns so bad when drainage is left on my leg.'" On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds were given closer together. Resident has been seen by NP. Area on leg measures 16 cm x 10 cm draining et macerated with some greenish color at first change when NP was in room." On 10/12/15, 2:27 p.m. LPN-F noted, "[R118] continues to c/o pain. PRN pain meds given x 2. Resident makes requests for dressing changes. Leg continues to be painful et macerated during dressing changes." On 10/15/15, at 12:09 p.m. LPN-J noted, "Treatment completed to RLE... C/o pain while treatment is being completed, had received pain med prior to tx [treatment] being done. States that it hurts when it is open to air." On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication." During interview on 10/26/15, at 10:42 a.m. nursing assistant (NA)-A stated, R118 has pain in her legs and she had seen her "pretty upset and crying." NA-A stated has seen R118 in pain and/or has complained of pain to her almost daily.	F 309		

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NA-A stated she told the facility nurses when R118 complained of and/or appeared in pain, to see if she could be given any pain medication. NA-A stated the pain medications seemed "somewhat effective, [but] never 100% [effective]."

During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's pain was mainly in her right lower leg, where she had an open area. RN-H stated the area has been improving, but was taking a long time. Upon review of the EMAR, RN-H reported R118's pain rating was typically around an 8 (0-10 pain scale) prior to receipt of her PRN pain medications. She reported R118's physician was at the facility every Thursday and was responsible for monitoring to ensure her pain management regimen was sufficiently effective. RN-H stated the most recent notation of the physician/ nurse practitioner commenting on her pain was the physician's progress notes, on 10/8/15. RN-H reported R118 had attended a wound clinic, but stopped going after 9/23/15, because she was very upset and did not want to go there anymore. RN-H stated she had spoken to R118 about her pain, as recently as 10/14/15, and she had indicated satisfaction with her pain management regimen. Upon inquiry as to R118's acceptable level of pain, RN-H replied she was unsure. RN-H stated that she was aware R118 had significant pain with dressing changes, but believed the current pain management regimen was effective for her. She stated the nature of R118's wound was going to result in some, inevitable pain during dressing changes. However, when told of the observed dressing change on 10/22/15, RN-H denied knowledge of R118 having reactions to that extreme. RN-H stated, "If she [R118] is saying

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she is having that much pain, she is having that much pain." RN-H denied any reports of pain concerns for R118, from the facility nurses or NAs. RN-H stated, she expected staff would have updated the physician if/when they identified unmanaged pain, as the physician could have looked at getting an increase in R118's pain medication. RN-H stated R118's use of the ice pack was typical, however, "If that was what we were seeing, then that would not be a sufficient management of her pain." RN-H confirmed, R118's pain should have been reassessed. RN-H confirmed the facility used section J of the MDS as their sole pain assessment, which was only completed on a quarterly basis.

During interview on 10/26/15, at 5:11 p.m. the director of nursing (DON) stated she gas completed R118's dressing changes on a frequent basis. She made sure R118 was medicated about one hour before the dressing change and asked her (R118) frequently throughout the dressing change, how she was doing. The DON stated she soaked the Silversorb in a significant amount of normal saline to keep it from sticking to her leg and made sure she had an ice pack to use for her leg at the time of dressing change. The DON stated she typically looked at R118 and tried to get her to laugh, distracting her during the dressing change. The DON stated she felt these interventions were "as effective as they can be." The DON stated, when R118 was first admitted to the facility, the dressing changes were much more painful than they were presently. The DON stated she had never seen R118 cry during a dressing change and upon discussion of the observed dressing change (10/22/2015), she denied having seen that kind of response from R118 any time she

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had completed or observed her dressing changes. The DON stated she expected some discomfort with this type of dressing change, but if R118 had demonstrated significant signs of pain as identified in the 10/22/15 observation, she expected the nurses to document this in the medical record and see what they could do about getting some different analgesic medications for her.

Although R118, had a stasis ulcer, had frequent progress notes that identified significant pain, and had nurses and nursing assistants who observed R118 in pain, either during her dressing changes or other times during the day. R118 only received Gabapentin 300 mg twice a day, for a routine scheduled pain medication, and Ultram 50 mg PRN for pain and oxycodone 5 mg PRN for moderate to severe pain. R118 only received the Gabapentin 300 mg prior to her dressing change in the morning of 10/22/2015, and then received oxycodone 5mg after the dressing change was completed. Even though R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change. The facility did not comprehensively assess and developed an appropriate pain management interventions to assist in reducing her pain. This resulted in actual harm for R118.

The facility's Dressing Change, Clean policy dated 6/14, directed nursing to check physician orders to see if a resident required an analgesic prior to completion of dressing changes and to administer any analgesic medication as ordered. The policy did not further address pain management during dressing changes. Facility policies regarding pain management with dressing changes were requested, but no

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F 309	Continued From page 77 additional policies were provided. WHEEL CHAIR POSITIONING: R57's quarterly MDS dated 9/22/15, identified R57 used a wheelchair for mobility, and required extensive assistance with activities of daily living (ADLs). R57's care area assessment dated 4/21/15, indicated she had contractures, and limited range of motion. R57's care plan dated 9/23/15, indicated alterations in mobility related to increasing weakness and directed staff to refer to physical and occupational therapy as needed. A Resident Progress Noted dated 9/13/15, indicated "pillow given to resident on wheel chair due to resident leaning to right." A Resident Progress Note dated 9/5/15, indicated R57 was up in wheel chair and would "drift off, leaning to right." During and observation on 10/19/15, at 8:16 p.m., R57 was sitting in a wheel chair. She appeared to be sleeping with her head resting on her right arm, leaning to her right. On 10/20/15 at 9:58 a.m., R57 was again observed sitting in her wheel chair, leaning to her right side. On 10/21/15, at 8:58 a.m., R57 was leaning to her right side in her wheel chair with her head resting on her tray table. On 10/23/15, at 3:55 p.m., R57 was observed sitting in her wheel chair, leaning to her right side with her head resting on a pillow that was placed on the right arm rest of her wheel chair. Although R57 continued to lean to the right, there were no supports noted in her wheelchair to support her trunk that prevented her from leaning. During and interview on 10/23/15, at 11:32 a.m., NA-B stated R57 refuses to lay down a lot of the time, that's why we put pillow by her head. NA-B	F 309		

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further stated R57 "has always leaned to the right side, not sure why that is."

During an interview on 10/23/15, at 11:48 a.m., occupational therapy assistant (OTA)-J stated R57 was recently given a right lateral support for her wheel chair. OTA-J stated R57 was seen for a referral "about a month or so ago," but was not picked up for ongoing therapy. He felt R57's chair size was appropriate but that (R57) was more fatigued.

During an interview on 10/26/15, at 1:53 p.m., NA-T stated, R57 is like that "all the time," they get her up for breakfast and then she falls asleep in her wheel chair. NA-T further stated, she used to lean a little but her leaning has been going on for the past few weeks.

During an interview on 10/26/15, at 2:07 p.m., LPN-H stated, some they they have difficulty getting her (R57) to lay down. Sometimes they will place a pillow under her head to buffer the uncomfortable position but, "she always looks like that." LPN-H further stated, she though this was her second chair, and was unsure if (R57) had lateral supports or if they helped or not. R57 was at high risk for falling out of her chair because she is always leaning to her right. LPN-H further stated, R57 had been screened by occupational therapy for positioning, but was unsure if she had been re-evaluated.

During an interview on 10/26/15, at 2:32 p.m., occupational therapist (OT)-K and OTA-J stated, they had received a referral in September for R57 because of her leaning and gave her a lateral supports. They also recommended she (R57) lie down if tired and listed the potential for several

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F 309	Continued From page 79 negative outcomes of a sore back, and neck. At the time of the referral in September 2015, the lateral support was providing R57 with the amount of assistance she needed to sit up right and be able to propel herself in her wheel chair. OT-K and OTA-J further stated, R57 was "never leaning that bad when we saw her" and that her current positioning was a change and she should have been referred back to therapy for an evaluation. A policy addressing positioning for residents was requested, but was not provided.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. Findings include: LACK OF NAIL CARE:	F 312	F312-E Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or	12/29/15

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F 312	Continued From page 80 R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete her personal hygiene. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room. R5 had visibly long fingernails on both hands with a dark colored substance underneath several of the nails. R5 stated he was diabetic so "not everybody can cut them", but added his preference would be to have shorter nails. On 10/22/15, at 9:01 a.m. R5 continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. nursing assistant (NA)-T stated R5 seldom refused cares or assistance from staff, and nail care was to be completed on residents scheduled bath days. At 2:03 p.m. NA-T observed R5's nails and stated they were too long, and "not very clean underneath." Further, NA-T stated they were unaware of any preference of R5 to have long, dirty fingernails and they should be trimmed. During interview on 10/22/15, at 2:33 p.m. licensed practical nurse (LPN)-A observed R5's long, dirty fingernails and stated "they need to be cut." Further, LPN-A stated R5 was dependent on nursing staff for his nail care, and his nails should have been trimmed and cleaned on his bath day. When interviewed on 10/23/15, at 11:23 a.m. registered nurse (RN)-A stated R5 required assistance to complete his nail care, and his nails should have been cleaned and trimmed, "[They] should be taken care of when they get their bath done."	F 312	otherwise identified the same. It is the policy of Lake Ridge Care Center to provide the necessary services to maintain good nutrition, grooming and personal and oral hygiene. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: On 22 Oct 15, after Resident 5 refused, nurse was able to trim resident's nails. Resident 5 and Resident 64 nails were audited and were cleaned and trimmed. An interview with resident to obtain preferences completed on Resident 126 and was offered alternative options of chux, disposable products etc . Resident stated it was his desire to continue use of newspaper to enhance independence, but with improved health condition he did not feel this would be needed any longer. Resident stated with condition improvement he is now using commode at bedside for most all toileting needs. Resident and NAR Care Guide updated to reflect residents preferences for maintaining as much independence as possible. Resident 19 received their bath on 27 Oct 15. Resident 45 received their bath on 28 Oct 15. Resident 19 and Resident 45 will be interviewed for bathing preferences by 13 Dec 15. 2.Actions taken to identify other potential	

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F 312	Continued From page 81 R64's quarterly MDS dated 9/15/15, identified R64 had moderate cognitive impairment, and required extensive assistance from staff to complete his personal hygiene. During observation on 10/20/15, at 9:36 a.m. R64 was seated in a standard wheelchair in his room. R64 had visibly long fingernails with several nails having a dark colored substance underneath several nails. R64 stated he preferred to have shorter kept nails adding they "could use a clip." On 10/22/15, at 9:04 a.m. R64 was seated in his wheelchair outside his room, and continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. NA-T stated R64 had never refused cares or staff assistance to their knowledge. At 2:03 p.m. NA-T observed R64's nails and stated they were "very long" and should be cleaned and trimmed. During interview on 10/22/15, at 2:33 p.m. LPN-A observed R64's nails and stated they should have been cleaned and trimmed on his bath day. When interview on 10/23/15, at 11:23 a.m. RN-A stated R64 had no desired preference to have long, dirty fingernails and they should have been cleaned and trimmed on his bath day. A facility policy on grooming and nail care was requested, but none was provided. LACK OF BATHING: R45's annual MDS dated 8/11/15, identified R45	F 312	residents having similar occurrences: All resident's nails were observed to ensure nails were trimmed. Random audits on incontinent residents to ensure timely assistance with toileting based on assessed needs. Residents were interviewed using a modified CMS Resident QIS Interview tool to include bathing preferences. Audits completed to ensure residents receive timely bathing. 3.Measures put in place to ensure deficient practice does not recur: Care staff education completed and training content included completing resident cares (nail care, toileting, and bathing) and following resident care plan. Facility revised process for interviewing residents about bathing/showering preferences upon admit and with comprehensive RAI reviews. Facility process and procedure for bathing was review and revised. Care staff and Activities educated on change of practice with bathing preferences and honoring Resident Choices by 13 Dec 15. 4.Effective implementation of actions will be monitored by: Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. 10 timing audits	

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F 312	Continued From page 82 had intact cognition, and required physical assistance from staff to complete her bathing. During interview on 10/22/15, at 1:46 p.m. R45 stated she does not always receive her schedule bath because of the facility being short staffed. Further, R45 stated not receiving her bath consistently makes her "angry", and she would like to have her bathing completed. Facility Lakeside Oasis Bath Records dated 9/14/15 to 10/21/15 were reviewed. The records were constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. R45's name was identified on the records, however for three weeks there were no staff initials identified next to her name to identify she received bathing. The spaces provided to record initials were left blank. When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R45 enjoyed her showers, but added they were sometimes not completed due to a lack of staff to complete them. During interview on 10/23/15, at 11:59 a.m. RN-A stated she was not aware R45 was not receiving her baths as scheduled, but added it "wouldn't surprise me." Further, RN-A stated R45 should have been given her baths as scheduled. R19's quarterly MDS dated 9/29/15, identified R19 had intact cognition, and required assistance from at least two staff to complete her bathing. During interview on 10/22/15, at 2:11 p.m. R19	F 312	for toileting will be completed each month for three months. 10 bathing audits will be completed monthly for three months. The data collected will be presented to the Quality Assurance and Assessment Committee quarterly. At that time the Quality Assurance and Assessment Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	

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stated she was supposed to receive a bath twice a week, but had to go without her baths at times because there was "not hear enough" staff at the facility. Further, R19 stated she wanted to receive all of her scheduled baths as it was "very" important to her.

A facility Mill Creek Bridge Weekly Bath and Vital List dated 8/3/15 to 10/21/15, identified R19 was scheduled for a bath twice a week. The listing was constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. However, R19 was not provided her baths for four of sixteen scheduled times according to the record.

When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R19 enjoys her baths, but added some have been missed because there were no staff available to complete it.

During interview on 10/23/15, at 11:59 a.m. RN-A stated her expectation was for staff to complete bathing as required for residents.

A facility policy on bathing was requested, but none was provided.

LACK OF TIMELY PERICARE:

R126's admission Minimum Data Set (MDS) dated 9/25/15, identified R126 had intact cognition, required extensive assistance for toileting and personal hygiene, and was continent of bowel.

R126's care plan dated 10/12/15, identified R126 had an alteration in his elimination related to

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decreased mobility, but remained continent of bowel. Further, the care plan directed staff to complete, "Pericare with assist of 1 with am [morning] and HS [hour of sleep] cares." The care plan did not identify if or when pericare should be completed for toileting not associcated with those set times.

During interview on 10/20/15, at 3:22 p.m. R126 stated he was dependent on staff for help with pericares after having a bowel movement, however he did not always recieve timely assistance with this. R126 used a bed pan, but stated his bottom would ge sore if he sat on it for too long, so he would remove himself from the bed pan, and place newspaper underneath of himself to prevent the bed linens from becoming soiled while he waited for staff assistance with pericares.

When interviewed on 10/26/15, at 10:27 a.m. nursing assistant (NA)-A stated she had assisted R126 with toileting and pericares before, and noticed feces soiled newspaper on his bed before. NA-A stated she was unaware R126 was using it as a barrier to prevent the linens from becoming soiled while waiting for staff assistance.

During interview on 10/26/15, at 2:18 p.m. registered nurse (RN)-H stated she was unaware R126 was using the newspaper after having a bowel movement while he waited for assistance with pericares.

A letter submitted post survey exit dated 10/28/15, authored by NA-T noted, "A couple of times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put

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F 312	Continued From page 85 himself on bedpan, notifying staff only when he was done." A letter submitted post survey exit, dated 10/30/15, authored by NA-D noted, "[R126] chose to use newspaper under himself even though I told him he didn't need to do that and we would change linen if it got soiled. He continued to put newspapers under him." A facility policy on toileting and pericare was requested, but none was provided.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote urinary continence for 1 of 3 residents (R64) reviewed for urinary incontinence. Findings include: R64's quarterly Minimum Data Set (MDS) dated	F 315	F315-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission	12/29/15

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F 315	Continued From page 86 9/15/15, identified R64 had moderate cognitive impairment, required extensive assistance with toileting and was, "Always incontinent" of bladder. R64's Nursing Observations 3.0 Assessment dated 9/18/15, identified R64 to be "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." The assessment did not identify if any or what type of a toileting program needed to be implemented for R64, to decrease R64's incontinence. R64's care plan dated 9/21/15, identified R64 had an, "Alteration in elimination r/t [related to] weakness following hospitalization", but R64 was, "Aware of the need to void/defecate." Further, the care plan directed staff to, "Toilet per request", and, "Monitor for changes in elimination patterns and reassess quarterly and prn [per request or as needed]." During interview on 10/22/15, at 9:43 a.m. nursing assistant (NA)-T stated he helps R64 to the bathroom when he requests as care planned, but has noticed R64 to be "more incontinent of urine" lately. Further, NA-T was unaware of any set toileting schedule for R64. During observation of care on 10/23/15, at 7:24 a.m. R64 was assisted to the toilet by NA-F. NA-F removed a visibly soiled white incontinence pad from R64, and placed it in the trash stating R64, "Had the wrong kind of pad on." R64 should have had an "extra absorbent" green colored pad on during the night to help reduce irritation to his skin from being incontinent. NA-F stated R64's removed incontinence pad "was full" of urine, as R64 was typically incontinent in the morning, but	F 315	against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to comprehensively assess and develop interventions for promote urinary continence. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 64 will have a comprehensive toileting assessment completed and the care plan updated. 2.Actions taken to identify other potential residents having similar occurrences: Based on software reports and information gathered from daily IDT meetings, all residents that are incontinent are at risk from this deficient practice. Incontinent residents bladder assessments will be reviewed to ensure individualized toileting plans match resident needs with MDSs upon admission, quarterly and with significant changes. 3.Measures put in place to ensure deficient practice does not recur: Facility practices on Care Planning and Toileting were reviewed and revised, as needed, with education provided to licensed staff by 13 Dec 15. Daily IDT meetings were established on 30 Oct 15	

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F 315	Continued From page 87 when assisted to the toilet would sometimes void. Further, NA-F stated R64 was unable to verbalize when he needed to use the restroom, so she helped him "every two hours" to the restroom. During interview on 10/23/15, at 11:34 a.m. registered nurse (RN)-A stated R64 was able to voice his need to use the restroom, "Most of the time", and should be helped with toileting every two hours. R64 should not be incontinence of urine, "More than a couple times a day," with his toileting ability, and the assessment completed on 9/18/15 should have identified a toileting program for R64 to promote continence. Although R64's assessment identified him as "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." There was no indication if R64 needed a scheduled toileting program, or was a check and change (no attempts to place on the toilet) even though R64 had been using the toilet, and NA-F stated he did have some continent voids. A facility policy on urinary incontinence was requested, but none was provided.	F 315	to also aid in capturing residents potentially at risk. MDS's will be completed upon admission, quarterly and with significant changes, to determine the individualized toileting program. 4.Effective implementation of actions will be monitored by: Facility will complete five NAR Care Observations weekly for three months. Ten chart audits will be done monthly for three months for individualized toileting program. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/29/15

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F 323	Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety was assessed and interventions were implemented for 1 of 1 residents (R73) who spilled hot coffee on himself while attempting to carry the coffee between his legs and obtained nine second degree burns to his lower left extremity. This resulted in immediate jeopardy for R73, who remained at risk of serious injury when the facility failed to assess safety with hot beverages and implement interventions to prevent similar injuries. The immediate jeopardy began on 10/10/15, at 4:50 p.m. when R73 obtained nine second degree burns (blistering with partial thickness) to his lower left ankle and foot from the spilled hot coffee, and the facility failed to complete an assessment and implement interventions to prevent reoccurrence. On 10/21/15, at 6:06 p.m. the facility administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for R73. The IJ was removed at 10/23/15, at 8:24 a.m. but noncompliance remained at an isolated scope and severity level, which indicated actual harm that is not immediate jeopardy (Level G). Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, identified the resident had no cognitive impairment, required extensive assistance for bed mobility, transfers, locomotion on the unit, dressing, and toilet use. R73 required supervision with eating and had bilateral,	F 323	F323-G Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to prevent residents from being burned by hot beverages. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The coffee vending machine was unplugged and has been removed as of 22 Oct 2015. The coffee vending company has been contacted to remove the coffee vending machine. Resident 73 has been interviewed and has agreed to use a covered cup when drinking hot liquids. The resident assessment for R73 was reviewed and the care plan was updated on 10/21/15. The Administrator and Director of Nursing had a discussion with Resident 73 to explore options. Resident 73 has typically carried hot beverages between his legs in the past	

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F 323	Continued From page 89 functional limitations in range of motion, to both upper and lower extremities. R73's Care Area Assessment (CAA) dated 10/1/15, indicated R73 was at risk for falls due to weakness from Friedrich's Ataxia (a disease which caused progressive damage to the nervous system and manifested as poor coordination, spasticity in lower limbs, muscle weakness, and absent lower limb reflexes), with a history of numerous falls at home, and one fall since admission to the facility. The CAA indicated R73 required assistance with transfers, however, required reminders from staff to wait for help. A Fall Scene Investigation Report dated 10/10/15, at 4:50 p.m. indicated another (unidentified) resident's family member witnessed R73 fall from his wheelchair in the facility's lower level, between the vending machines and the rehabilitation dining area (hillside room). The report indicated R73 was holding coffee just prior to the fall, and lost strength, or appeared to become weak, and fell to the floor out of the wheelchair. When R73 was asked what he was trying to do just before the fall, R73 stated he had gotten a cup of coffee out of the vending machine. The report indicated R73 was alert and orientated, wearing shoes, and had recently received narcotic medication. The review indicated environmental factors related to the fall were hot coffee and R73's physical condition or diagnoses as contributing factors to the fall. The report indicated, "Resident is unable to carry hot item in [an] unsafe cup. Ask staff for help." The root cause of the fall identified, "Resident did not have the strength to hold [an] unsafe paper coffee cup." The Fall Scene Investigation Report did not identify if the resident and staff were educated regarding the need for	F 323	and has agreed to no longer do this and will ask for assistance when he would need to transport a hot beverage. 2.Actions taken to identify other potential residents having similar occurrences: The coffee vending machine was unplugged, labeled as out of order and was removed from the facility as of 22 Oct 2015. The facility has reviewed all events or incident reports for the past 6 months and have noted no other related injuries or burns of any kind. 3.Measures put in place to ensure deficient practice does not recur: The coffee vending machine was unplugged, labeled as out of order and was removed from the facility as of 22 Oct 2015. The coffee company Bernicks was contacted to remove the machine as of 21 Oct 2015 to prevent other residents from potentially receiving burns from hot liquids disbursed by the machine. The Administrator and Director of Nursing had a discussion with Resident 73 to explore options. Resident 73 has typically carried hot beverages between his legs in the past and has agreed to no longer do this and will ask for assistance when he would need to transport a hot beverage. 4.Effective implementation of actions will be monitored by: The Administrator will insure that the coffee machine is removed from the building on 22 Oct 2015. Director of Nursing, or their designee, will conduct and continue to review all incident reports	

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F 323	Continued From page 90 R73 to be assisted with obtaining coffee out of the vending machine, nor was there an assessment of the residents wheelchair related to the ability of R73 to safely carry the hot coffee to prevent further injury. An Event Details report dated 10/10/15, at 5:55 p.m. indicated, "Res. [R73] states his body went spastic as a reaction to the hot coffee pain on his foot- it is part of his disease process that made him stiffen to come out of his wheelchair and fall to the floor. Res. [R73] is able to get around the facility ad-lib [at will]... and make his own decisions based on his judgement for how to spend leisure time. Care plan was followed as assessed... Treatment continues to heal the burn sustained in this event." Another Event Details report dated 10/13/15, documented at 1:20 a.m. noted R73 had obtained a skin injury on 10/10/15, described as, "Blisters left foot r/t [related to] coffee spill." The report identified multiple burns to the circumference of his left ankle and the top of his left foot, with moderate serous drainage and pain present at the injury site. Characteristics of the skin injury indicated blisters, light redness of skin, and superficial burns (injury to top layer of skin-epidermis). R73's activity at the time of injury was identified as, "Fell forward with hot coffee in hand," and poor upper body control was noted as a possible contributing factor to the fall/ burn. The skin injury dimensions to the left ankle and foot were detailed as follows: Site 1- 1.5 centimeters (cm) by (x) 2 cm, oval Site 2- 1.5 cm x 2 cm, oval Site 3- 0.5 cm x 0.5 cm, circular Site 4- 0.5 cm x 0.5 cm, circular Site 5- 3 cm x 2 cm, no shape noted	F 323	to monitor for any burns for causal effects for appropriate interventions. Residents will continue to be monitored daily through dietary and nursing observation by trained employees that are aware of the need of adaptive equipment to assist the residents in safely dining in our facility. Residents will also be interviewed at care conferences to determine the need for adaptive devices. The need for any adaptive devices will be documented in the resident chart and will also be listed on the resident tray card. Resident 73 will be interviewed and observed weekly for three months to insure he is asking for assistance in transporting hot beverages. Audit results will be presented at the next Quality Assurance and Assessment committee meeting. 5.Those responsible to maintain compliance will be: The Dietary Manager or designee is responsible for maintaining compliance with adaptive interventions to prevent potential injuries with hot beverages. Completion date for certification purposes only is: 22 October 2015	

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F 323	Continued From page 91 Site 6- 6 cm x 6 cm, oblong Site 7- 2 cm x 2 cm, no shape noted Site 8- 3 cm x 2 cm, no shape noted Site 9- 3 cm x 3 cm, no shape noted R73's nursing progress notes were reviewed from 10/10/15, through 10/21/15, and indicated the following: 10/10/15, at 5:14 p.m. licensed practical nurse (LPN)-B indicated staff were alerted R73 had fallen out of his wheelchair. R73 was found lying on the left side of his body and partially on his back. No injury was obtained from the fall, however, when R73's wet clothes were removed, multiple, popped blisters to the left foot were found, and redness was also noted to both of R73's thighs from the coffee spill. On 10/12/15, at 4:01 p.m. LPN-C indicated a physician order had been obtained for Keflex (an antibiotic medication) 500 milligrams (mg), twice daily for R73's left foot burn. On 10/13/15, at 1:50 a.m. LPN-D indicated the blisters to the top of R73's left foot were intact and fluid filled. The blisters to the lateral, medial, and posterior sides were noted as opened. On 10/14/15, at 1:24 p.m. registered nurse (RN)-A indicated the dressing to R73's left foot burns was changed and, "Blisters on top of foot, on the inner ankle region, and outer ankle region, most of the blisters have popped at this point. Whole foot is swollen, red, and covered with freshly popped blisters. Inner ankle blister is still intact at this point. Patient denies pain to this area." R73's nursing progress notes had no assessment related to R73's safety related to safely carrying coffee after obtaining it from the vending	F 323		

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machine, there was no indication R73 was educated on asking for staff assistance, nor was there evidence staff had been educated on ensuring R73 was monitored and assisted with coffee to prevent further burns.

R73's care plan dated 10/16/15, identified a potential alteration in skin integrity related to his being wheelchair bound, ataxia (loss of full control of body movements) and medication use. The care plan noted, "At risk for skin tears, etc.. Lt. [left] foot burn from hot coffee spill 10/15." The care plan goal was for the burn to heal without further complications, with interventions including the following: Treatments as ordered by the physician, Wound Care Standing Orders were to be followed as needed and as appropriate for skin issues, lotion as needed to moisturize skin, changes in skin were to be monitored with cares and as needed, a pressure reduction cushion was to be used in his wheelchair, a pressure reduction mattress was to be used on his bed, skin checks were to be done with bathing and as needed, and tissue tolerance testing was to be done per the facility policy to monitor for skin risk, with reassessments of skin risk as needed. The care plan also identified R73 as at risk for falls related to generalized weakness, and fall interventions included assessing his risk quarterly and as needed, monitoring for safety and assisting with mobility as needed, preventative measures of removing the hoyer sheet after use, and physical therapy as ordered and as needed. The care plan did not address R73's safety with hot beverages, transportation of hot beverages, or how to minimize his risk for burns/ injury similar to that which occurred on 10/10/15.

The undated nursing assistant (NA) care sheet

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(identified as what the NAs use to know specific, individualized resident care needs), lacked any information regarding R73's burn, or direction of safety interventions to minimize the risk for burns/ injury, similar to that which occurred on 10/10/15. There was no indication staff had been educated to ensure R73 was provided assistance when obtaining coffee out of the vending machine and utilizing a safe cup to prevent further burns.

During interview on 10/20/15, at 9:44 a.m. director of nursing (DON) stated on 10/10/15, R73 had gotten a coffee from the facility vending machine and spilled coffee, which led to a fall from his wheelchair as a reaction to the spilled coffee.

During observation and interview on 10/21/15, at 9:21 a.m. R73 was lying in his bed. His left foot was wrapped in gauze. R73 stated he had multiple burns on his left foot from spilling coffee. R73 stated he had purchased coffee from the vending machine downstairs in the facility and was propelling his wheelchair and his wheels were grasped somewhat suddenly on the floor, and his coffee spilled which he was carrying between his leg, and the coffee spilt into his boot on his left foot. R73 stated when it happened he had severe pain, however, the pain has gotten better. During this observation, R73 was observed getting a needle nosed pliers from his belongings nearby and used it to lift the tab of his Mt. Dew pop can in order to open the can. R73 held the pop can inside a can coozie, and when he took sips of his pop he lifted the beverage up to face level, and raised his neck to bring his mouth to the lip of the can.

On 10/21/15, at 2:30 p.m. the DON recorded the

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following progress note, "When writer asked, [R73] stated he... will not be using the coffee vending machine alone. 'I'm not going to do that again.' ...Business Office Manager took [R73] for a walk outside for fresh air and sun light in effort to help increase his mood." There were no other progress notes since the coffee burn occurred on 10/10/15, to indicate any interventions were put into place to ensure R73 did not obtain further burns from the facility coffee vending machine.

During a follow up interview on 10/21/15, at 3:21 p.m. R73 stated he had just recently gone downstairs prior to this interview and was looking at the flavor selections offered from the facility coffee vending machine. R73 stated he wanted to try some of the flavored coffees out of the vending machine. However, he stated as he was determining what kind of flavored coffee he wanted, the (unidentified) business office employee told him he was not allowed to get coffee out of the coffee machine anymore so he would not get burned again. R73 stated he then asked an unidentified dietary staff downstairs if they could help him to purchase a coffee from the vending machine and they said no because they were not allowed to handle resident money. When asked why he could not have made the coffee purchase, but had the staff simply assist with retrieving and transporting the coffee for him, he stated he had not thought of trying that arrangement. R73 stated he was capable of putting his own money into the machine and getting his own coffee out of the vending machine. During this interview R73 was observed seated in his wheelchair in his resident room. His wheelchair had no arm rests, and there were no adaptations to the wheelchair to aid in holding a beverage or any other item. R73 was

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observed self propelling his wheelchair with his hands and his feet were on the footrests, and his left foot remained wrapped in white gauze.

During interview on 10/21/15, at 3:21 p.m. dietary aide (DA)-B stated she was not aware any residents had been burned by coffee, and had not been told R73 needed to be provided assistance, needed any monitoring, or required any special interventions in place related to obtaining coffee out of the vending machine located outside the dining room.

During interview on 10/21/15, at 3:21 p.m. cook (C)-B stated she had seen R73 using the facility coffee vending machine in the past. C-B had not been told there were any residents who should not be using the coffee vending machine, nor was she aware R73 had experienced burns from the coffee on 10/10/15.

During interview on 10/21/15, at 3:28 p.m. NA-B stated she referred to the NA care sheet for direction on what individualized cares and interventions were needed for each specific resident, and stated the care sheets were updated daily by the clinical coordinators with any changes in care. NA-B stated the nurses also told the NAs of any significant changes with residents. NA-B stated she was not aware of any residents who had received coffee burns, nor was she aware of any special interventions in place for R73 related to drinking hot beverages or requiring supervision and/ or assistance to obtain coffee from the vending machine.

During interview on 10/21/15, at 3:30 p.m. NA-C stated she was aware R73 had a burn on his foot from spilling coffee, however, she stated there

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had been no changes to his plan of care, nor was staff provided any education regarding R73 carrying, obtaining, or drinking coffee from the vending machine.

During interview on 10/21/15, at 3:41 p.m. NA-D stated she was aware R73 had purchased a coffee from the vending machine downstairs and burnt himself. NA-D stated staff were to watch him with coffee or hot liquids, however, she stated she could not control where he went when she was in rooms taking care of other residents, and stated, "He [R73] can do what he wants." NA-D stated there was nothing specific on R73's NA care sheets related to coffee or hot liquids.

During interview on 10/21/15, at 4:07 p.m. DON stated R73's burn happened on a weekend, and confirmed that all the information, reports, assessments, interventions, and investigation related to R73's coffee burn had been provided, and the event report contained all the information for the facility investigation and the interventions. The DON stated R73's physician and family were notified of the burns, and orders were obtained for treatment of the burns. The DON stated she talked to R73 about the burn, and the resident told her he was, "Never going to touch that coffee machine again." The DON stated the intervention to prevent further injury from coffee burns for R73 was to speak to him about not using the coffee vending machine again. The DON stated R73's care plan was updated to address the fall that happened as a result of the burn, but no interventions had been put into place to prevent R73 from burning himself with coffee again, other than the discussion she had with the resident telling him not to use the vending machine again to get coffee. The DON stated she was not

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aware R73 was downstairs earlier this day wanting to purchase another coffee from the vending machine. She stated she was aware R73 was downstairs earlier with the business office manager (BOM) and had been emotional about his placement at the facility, but was not aware R73 attempted to get coffee from the vending machine. The DON stated R73 was safe to "go out ad lib" in the facility, and the assessment of R73's safety after the burn was "just what I have documented here [on the event report] as a result," as well as the information she added earlier today to the nursing progress notes.

During a follow up interview on 10/21/15, at 5:18 p.m. R73 stated he typically ate his lunch and supper meals in the main dining room. R73 stated he did not need to use any modified utensils or adaptive equipment for eating. R73 also stated he, "Stripped it [wheelchair] all down" himself, because he did not like having arm rests on the chair as it made it easier to propel the wheelchair with his arms/ hands. R73 stated his wheelchair needed to stay like it was so he was able to move himself around the facility.

The facility's Wound Prevention and Treatment policy dated 6/14, directed individualized, preventative, interventions be developed based on the skin and risk assessments of each resident.

The facility's Injury Documentation policy dated 6/14, directed documentation of injuries include an evaluation of contributing factors for the skin injury, a root cause of injury, and interventions in place. The care plan for skin integrity was to be reviewed and revised based on the resident's treatment and needs.

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F 323	Continued From page 98 The immediate jeopardy that began on 10/21/15, at 6:06 p.m., was removed on 10/23/15, at 8:24 a.m. when the facility completed the following interventions: - The coffee vending machine was removed from the facility on 10/22/15. - R73 agreed to use a covered cup when drinking hot liquids, and the residents care plan was updated to ensure staff was aware of the safety intervention. - If R73 would like to transport hot beverages he has agreed to ask staff for assistance vs transporting it between his legs. - All residents in the building would continue to be monitored by dietary and nursing staff who had been trained to ensure resident needing adaptive/ safety equipment were assessed and provided the necessary adaptive equipment to ensure safety. On 10/23/15, from 7:45 a.m. to 8:08 a.m. direct care staff, including dietary staff were interviewed and explained their knowledge of ensuring R73 was provided a covered cup when drinking hot liquids, and would be assisted to transport any hot liquids he wished to take out of the dining room area.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		12/29/15

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F 333	Continued From page 99 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 1 residents (R45) who had a medication error in which they received the incorrect dosage of insulin that caused low blood sugars with physical symptoms. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated the resident was cognitively intact, had diagnoses of diabetes mellitus, and received daily insulin injections. Review of the Buffalo Clinic Telephone order report dated 4/8/15, indicated the facility was instructed by the clinic to notify the physician if R45 had blood sugars below 80 milligram/deciliters (mg/dl), normal blood sugar range 80-120 mg/dl. Review of the Allina Health Clinic Buffalo note which included physician orders dated 4/16/15, indicated R45 was to, "Continue Lantus [long acting insulin] as of the last dosage which was 37 units in the morning. No night time dosage for now." The Lake Ridge Care Center signed Physician Order (PO) Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. The PO did not direct staff to give a night time dose of Lantus. An Allina Health office visit note dated 4/20/15, indicated R45 was to go, "Back on lantus 37 units	F 333	F333-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure that residents are free of any significant medication errors. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 45's insulin order clarified by medical provider on 27 Apr 15. Nurses and HUC were identified that were responsible for transcription of the insulin. Medication error event was created. HUC received education on Medication error and transcription; both nurses are no longer employed at facility. 2.Actions taken to identify other potential residents having similar occurrences: All residents who receive insulin are potentially at risk from this deficiency.	

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F 333	Continued From page 100 at bedtime." However, there was no indication R45 had been receiving Lantus at bedtime prior, as the resident had only been taking Lantus 37 units in the morning. Although this PO added 37 units more of insulin, than R45 was currently receiving. The facility did not clarify the significant increase in insulin R45 was to receive from the Allina physician. Review of R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in the morning. However, on 4/20/15, Lantus at HS (at bed time), was implemented, along with the Lantus 37 units in the morning; doubling R45's dose of insulin. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15, to 4/26/15. Review of R45's Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45's blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/25/15, indicated the residents blood glucose was checked when the resident was eating breakfast and was only 51 mg/dl. Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15. R45's Resident Progress Note dated 4/26/15, at 3:30 a.m. indicated the residents blood glucose was 51 mg/dl. Review of the medical record did	F 333	Residents who receive insulin will be identified and medical provider orders verified for accuracy against eMAR. 3.Measures put in place to ensure deficient practice does not recur: Licensed staff and HUCs will receive education on diabetes, transcription and medication orders by 13 Dec 15. Facility procedure for transcription and medication errors reviewed and revised; orders will be verified by licensed nurse after transcription. 4.Effective implementation of actions will be monitored by: Five residents who have insulin orders will have MD orders verified against eMAR monthly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 333	Continued From page 101	F 333		

not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15.

R45's Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated, "Resident had low BS (blood sugar) this morning; was sweating and shaky. She had a BS of 38." The physician was called at 8:44 a.m. and updated on R45's low blood sugar.

A Buffalo Clinic Telephone Communication sheet indicated on 4/27/15, at 8:42 a.m. Lake Ridge called the clinic regarding R45's low BS in morning of 38 mg/dl. The Telephone Communication form indicated at 4:46 p.m. Lake Ridge called the clinic back wanting to know if the patient should actually be on 37 units of Lantus at bed time, as the facility just noticed the insulin orders did not match up.

A Buffalo Clinic Telephone order report dated 4/27/15, medical doctor (MD)-B indicated at 5:34 p.m., "Discussed with [staff] by phone. As of 4/20/15, visit had written to return to Lantus 37 units at bedtime, when it should have been once daily MORNING DOSE> Clarified with [staff] patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." MD-B ordered Lantus 37 units once daily in the morning as prior to hospital stay.

R45's Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated, "Resident had been receiving Lantus 37 units BID (twice daily) since 4/20, miscommunication written upon return from appointment. Spoke with [MD-B] and the HS dose has been d/c'd [discontinued] and will continue the 37 units in AM (disregard previous T.O. (telephone order)."

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F 333	Continued From page 102 During interview 10/26/15, at 9:30 a.m. director of nursing (DON) stated she was not aware of the insulin medication error that had occurred for R45, and stated she was unable to locate a medication error report. The DON stated the nurses should have called the physician when they noted the order for Lantus to be given at HS on 4/20/15, since the resident had not received that dose before, and the order was doubling the current insulin she was receiving. The DON stated that she had not checked any other residents orders to see if this was reoccurring problem. DON stated she did not do any staff training related to the significant medication error, because she was not aware the error occurred until survey on 10/26/15, six months after the error occurred. Although R45 was previously on Lantus 37 units in morning only, and had a history of low BS after the order to double the residents insulin dose on 4/20/15, the facility failed to clarify with the physician the additional order of Lantus 37 units at HS, nor did the facility contact the physician when R45 had low blood sugars on 4/22/15, 4/25/15, and 4/26/15. The facility did not contact the physician until 4/27/15, 7 days after R45's insulin dose was doubled, when the resident had a low blood sugar of 38 and experienced symptoms. Also, there was no indication they looked at other residents, and educated staff to prevent other potential medicaiton errors.	F 333		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or	F 353		12/29/15

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F 353	Continued From page 103 maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K,	F 353	F353-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center	

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F 353	Continued From page 104 COTA-J, SM-A and SM-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents who currently resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: > Refer to F241: The facility failed to ensure timely assistance with toileting aftercare's and failed to ensure appropriate incontinence products were provided, for 1 of 2 residents (R126) who expressed concerns of undignified care and services. > Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. > Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. > Refer to F282: The facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. > Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were	F 353	to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: We have provided written plans of correction for F-tags F-241 for R126, F-242 for R73, F-244 for R27, R19, R45, R35, R21, F-282 for R5 and F-312 for R64, R44 and R19 relating to the care of these cited residents found in the findings of our most recent CMS-2567, and how we have and/or will address those respective issues. We will continue interview, select and train prospective nursing employees as they are available to provide the care needed to these cited residents. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected by these deficient practices. 3.Measures put in place to ensure deficient practice does not recur: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15; corporate HR will perform interviews and assist in hiring until open positions are filled, and selection of new employees will be done within the requirements of employment law. Nursing	

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F 353	Continued From page 105 dependant on staff for their care. RESIDENT CONCERNS ABOUT STAFFING: R126's admission Minimum Data Set (MDS) dated 9/29/15, identified R126 had intact cognition, and required extensive assistance to complete ADLs. During interview on 10/22/15, at 3:22 p.m. R126 stated he had to wait up to thirty minutes to have his call light answered to receive assistance with cares. R126 stated he needed staff assistance to use the restroom and get into his wheelchair, and he never knew how long it would take staff to answer his call light and that made him feel, "Anxious," and "Helpless." During a follow-up interview on 10/26/15, at 10:00 a.m. R126 stated his preference was to use a commode for toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He stated, he need help to get on and off the commode, but is unable to get onto the commode alone, and has to wait for staff to help. R126 reported he would have much rather used a commode for toileting and not a bed pan, because he doesn't get as "messy," But staff does not respond to his call light for assistance timely to help onto the commode, so he has to use the bedpan and not the commode, which he prefers to use. R55's quarterly MDS dated 9/15/15, identified R55 had moderate cognitive impairment, and required limited assistance from staff for ADLs. During interview on 10/20/15, at 9:13 a.m. R55	F 353	schedules have been re-created, and are posted for two-week time periods or more, and any vacant positions are posted on the schedule. These vacant hours are available to current employees, and are also called in to a pool agency if they cannot be filled before the pay period begins. Variably, weekly orientations have also been implemented to assist in staff getting onto the floor. Bonuses have been and will continue to be offered to fill vacant shifts, as well as increased night differentials. Advertisements for nurses and nursing assistants have been and will continue to be placed in local papers and online sources, such as Indeed, until open positions are filled. Locations that provide nursing assistant programs have been contacted to let them know of any open positions and how we can partner together to attract more applicants. A suggestion box was put into use to solicit input from employees, as well as using annual reviews and the EQIC meeting to address potential job duty issues. All employees were educated on what we are doing to attract new employees. We are hoping to hire a staffing coordinator to assist in scheduling and shift replacement. To allow for the proper care of our residents, we have also added on a new position, Resident Concierge Representative, to help assist in the needs of our residents. 4.Effective implementation of actions will be monitored by: Open positions and vacant shifts will be recorded on the schedule and an	

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F 353	Continued From page 106 stated she often had to wait for extend periods of time to get help to the bathroom, and was frequently incontinent because of waiting for so long. R55 stated the facility needed more staff to help residents with their cares, "They just don't have the people to work." R85's quarterly MDS dated 9/1/15, identified R85 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:03 a.m. R85 stated the facility had been, "Short of staff," for the past two or three months. R85 stated staff takes, "Quite awhile" to answer his call light to provide assistance with cares, and it had, "Been a big annoyance." R118's admission MDS dated 8/24/15, identified R118 had intact cognition, and required limited assistance from staff to complete ADLs. During interview on 10/21/15, at 11:34 a.m. R118 stated staffing seems worst on the weekend and in the evenings. R118 had a dressing change that needed to be completed, however, the resident had to wait over 6 hours for staff to complete this which caused the dressing to become saturated and drip fluids. R5's quarterly MDS dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 9:11 a.m. R5 stated the facility did not have enough staff, and	F 353	explanation of how those open positions or vacant shifts were covered will be written in the nursing schedule. If a shift cannot be filled for some reason, the Director of Nursing will be contacted, and that contact, time and vacancy will be written in the nursing schedule book. The Director of Nursing will inform the Administrator weekly for two months of open nursing department positions and shifts unable to be filled and the course of action to fill those positions and shifts, and as needed thereafter. All-staff meetings will be held monthly for three months. Each Employee Quality Improvement Committee meeting will have adequate staffing levels added to the agenda, with reports continuing to be provided to the quarterly Quality Assurance and Assessment Committee, to provide a system of allowing employees to discuss staffing levels to see if they are successful or not; the minutes of those meetings will be posted in the employee lounge. Adequate staffing levels will be on the agenda for each care conference, with attending residents and families being able to comment on whether changes with staffing levels are successful or not. Reports of adequate staffing will be evaluated and PDSA models will be implemented to continuously improve and enhance staffing. This data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting and the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued.	

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F 353	Continued From page 107 staff would often complain about being short staffed to him, and at times R5 had stated there was only one nurse working for an entire shift. R5 stated his call light will take, "Fifteen to twenty minutes," to get answered, and was once left on the commode for, "An hour and a half," before staff came to provide assistance. R73's admission MDS dated 10/1/15, identified R73 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/21/15, at 10:55 a.m. R73 stated he had waited for nearly two hours in the past for staff assistance to go to bed and for his call light to be answered. R73 stated the staff are over worked and under staffed for the residents to be provided the necessary cares in the facility. R35's quarterly MDS dated 10/6/15, identified R35 had moderate cognitive impairment, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:29 a.m. R35 stated the facility staff worked short nearly all of the time, and there had been times R35 would have to wait to use the bathroom but was incontinent due to not receiving timely assistance from staff to get to the restroom. R123's admission MDS dated 10/15/15, identified R123 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 12:20 p.m. R123	F 353	5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	

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stated she had waited for over an hour to get help to the restroom, causing her to, "Just use my diaper," which she stated made her, "Feel degraded."

R27's quarterly MDS dated 9/22/15, identified R27 had intact cognition, and required extensive assistance from staff to complete ADLs.

During interview on 10/20/15, at 10:24 a.m. R27 stated she had waited for over an hour to have her call light answered to receive assistance, and the facility needed to have more staff to provide the cares the residents needed.

FAMILY COMPLAINT'S ABOUT STAFFING:

During interview on 10/21/15, at 11:31 a.m. family member (FM)-G stated they had visited their family member in the past and used the call light requesting staff assistance and "Waited, and waited, and waited," over twenty five minutes for staff to respond. There had been multiple occurrences of waiting for the call light to be answered, and FM-G stated, "It [long call light response times] concerns me." FM-G stated they had been told the owners of the facility felt they were "Adequately staffed," but stated she disagreed and the facility needed to add more staff to help residents with cares.

During interview on 10/26/15, at 10:01 a.m. FM-H stated he had noticed oral cares were frequently not being completed because of the lack of staff at the facility. The call light had taken over one hour to be answered in the past, and was especially worse on the weekends.

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STAFF CONCERNS ABOUT STAFFING:

During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed.

During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time."

During interview on 10/22/15, at 1:23 p.m. NA-I stated the staffing at the facility was, "Not good," and there was frequently only one or two NA's on each hallway to provide cares to the residents. The residents frequently had to wait, and call lights were not answered timely because of the

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lack of staffing, "They [residents] don't get the care they should get." NA-I stated several staff members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves.

During interview on 10/22/15, at 1:36 p.m. NA-C stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff.

During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing. NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed.

During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We

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[staff] don't have time," to answer them. The administration had done nothing to help with cares, but "they expect" the floor staff to get the work done and only come onto the floor, "When you guys [state surveyors] are here."

During interview on 10/22/15, at 2:53 p.m. licensed practical nurse (LPN)-F stated staffing is "Not adequate," to care for the residents and their needs, and she was quitting her position at the facility because she valued her nursing license, and felt it was being put in jeopardy because of the lack of staffing and poor care being delivered as a result.

During interview on 10/23/15, at 7:07 a.m. LPN-B stated she felt the facility did not have enough staff to provide the necessary care to residents, and residents had to wait to get up for the day, and families voice frustration to the staff regarding the suffering care as a result of the poor staffing. LPN-B stated she recalled some dressing changes weren't completed because the nurse did not have time because they were busy trying to help provide the necessary care for the other residents.

During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was suffering overall. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked for floor staff's input on how to handle the short staffing situation.

During interview on 10/26/15, at 2:32 p.m.

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occupational therapist (OT)-K and occupational therapist assistance (OTA)-J stated the floor staff could use more help, and the biggest complaint they hear from residents was the lack of staffing and waiting, "Way too long for [call] lights," to be answered. OT-K and OTA-J stated they were not aware of any actions being taken by the facility to address the short staffing concerns.

During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in people to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done, "because you guys [state surveyors] are here."

During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix this.

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The facility LRCC (Lake Ridge Care Center) documents, which displayed the names of the staff working on the floor for each shift, dated 10/19/15, to 10/23/15, were reviewed. The document identified each unit of the facility (Oasis, Lake View Lane, Mill Creek Bridge, and Northwoods), and provided blank spaces in which a staff members name was written to identify were they were scheduled to work.

> On the AM shift, 10/19/15, the Oasis unit had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods each had open spaces identifying no staff were scheduled to work; and were left with just one nurse and one NA for each unit. The document identified six of the thirteen spaces used to identify staff, to be blank.

> On the AM shift, 10/20/15, the Oasis unit again had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods had open spaces with no staff names written in. Both units continued with just one nurse, and one NA working on the floor providing care for the residents. The document identified six of the thirteen spaces used to identify staff, to be blank.

> On the AM shift, 10/21/15, the Mill Creek Bridge had no NA displayed, only having a nurse assigned to provide care to the residents. Northwoods had one nurse and one NA to provide cares to the residents. The document identified seven of the thirteen spaces used to identify staff, to be blank.

> On the AM shift, 10/22/15, the Lake View Lane had no nurse identified, and only one NA. Mill

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Creek Bridge and Northwoods again each only had one nurse and one NA identified as providing cares. The document identified six of the thirteen spaces used to identify staff, to be blank.

> On the AM shift, 10/23/15, the Oasis unit had no staff name identified as being assigned to work on the unit, and the Lake View Lane did not have a nurse identified. The document identified five of the thirteen spaces used to identify staff, to be blank.

On 10/26/15, at 5:06 p.m. the director of nursing (DON) stated, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON stated the facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. DON stated the facility's staffing shortage began around the end of summer when students returned to college, and there were also eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident was discharged. When asked whether the facility had identified or addressed concerns of residents who were not receiving baths or oral cares, DON stated, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed

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F 353	Continued From page 115 to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		12/29/15

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F 356	Continued From page 116 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the daily staff posting was updated in a timely fashion at the start of each shift to reflect the actual employees working for each shift. This had potential to affect all 48 residents in the facility, staff, and visitors who wished to review the information. Findings include: During observation on 10/26/15, at 4:32 p.m. the Lake Ridge Care Center Report of Nursing Staff Directly Responsible for Resident Care posting was displayed in a hard plastic holder attached to the wall by the nursing station. The posting identified three registered nurses (RN), two licensed practical nurses (LPN), and four nursing assistants (NA) were working at the facility on 10/26/15, during the time period of "6:00 am to 6:00 pm." The bottom of the posting identified,	F 356	F356-C Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure that the daily posting of nursing hours is updated in a timely fashion at the start of each shift.	

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F 356	Continued From page 117 "The number of staff on duty at any given time may fluctuate." A LRCC (Lake Ridge Care Center) daily staff assignment sheet dated 10/26/15, identified the names of the actual staff working on the floor. The sheet provided blank spaces for staff names to be written with headings including, "RN", "Nurse of TMA [trained medication aide]", "LPN/TMA", and "NAR [nursing assistant, registered]." The sheet identified only two nurses (RN and LPN), although the posting indicated three RN's and two LPN's, and three NA's to be working on the floor, although the posting indicated four NA's on 10/26/15, during the "Day Shift 6a [am] - [to] 6p [pm]." The sheet had seven blank spaces left on the sheet with no staff names being identified. During interview on 10/26/15, at 5:35 p.m. LPN-A stated the night shift staff fills out the daily staff posting and displays it on the wall by the nursing station. When there are changes to the scheduled staff, it does not get updated to reflect the actual staff working on the floor, and she stated, "I don't think they [staff postings] ever get changed." During interview on 10/26/15, at 5:55 p.m. the director of nursing (DON) stated she was responsible to ensure the staff posting was correct and displayed timely. Once posted by the night shift, the posting was not updated to reflect the actual number of staff working on the floor, "Once its up, I kinda leave it." DON stated the posting should be updated timely and accurate at all times, "Because its a requirement." A facility Posting of Nursing Hours policy dated	F 356	To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Daily staff posting will be updated in a timely fashion at the start of each shift. 2.Actions taken to identify other potential residents having similar occurrences: All residents had potential to be affected by this deficient practice. 3.Measures put in place to ensure deficient practice does not recur: Education was provided to staff addressing the components of this deficiency related to the posting of staffing hours, and policy for posting staffing hours will be reviewed and revised to include procedure for updating tool with staffing changes by 13 Dec 15. 4.Effective implementation of actions will be monitored by: The Director of Nursing, or their designee, will audit posting of staffing hours on a weekly basis for three months. The data collected will be presented to the Quality Assessment & Assurance Committee meeting, quarterly, and at that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible for compliance.	

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F 356	Continued From page 118 12/10/14, identified the posting is completed and displayed, "Daily by the Clinical Coordinator or the nurse currently in charge of the department." However, the policy lacked a process or procedure for ensuring it is updated to reflect actual staff working each shift.	F 356	Completion date for certification purposes only is: 29 Dec 15	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure raw meat was stored in a safe manner to reduce the risk of cross contamination to other foods in 1 of 2 refrigerators observed in the main kitchen. This had potential to affect 15 of 15 residents who could have consumed the potentially affected foods that was under the raw product. Findings include: During the initial tour of the facility kitchen on 10/19/15, at 6:21 p.m. a Norlake Advantage refrigerator was opened and inspected. The fridge had 4 shelves, and sitting on the top shelf was a plastic container which contained a single,	F 371	F371-E Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center	12/29/15

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F 371	Continued From page 119 un-cooked chicken breast. The container was labeled, "CHX [chicken] BREAST - RAW - 10/17," and there were visible light pink colored juices on the bottom of the container. The shelves below the raw meat contained several other food items including a white tray which contained approximately ten non-sealed, bagged raw vegetables, and a plastic container without a lid of approximately five non-sealed, bagged servings of Spanish rice. During observation of meal preparation on 10/21/15, at 9:11 a.m. (two days later) the plastic container with raw chicken remained in the Norlake refrigerator on the top shelf. However, there was now an additional plastic container of raw turkey burger patties on the top shelf labeled, "T. Burgers 10/15 and 10/18". The plastic tray of non-sealed, bagged vegetables and Spanish rice remained underneath of the containers of raw chicken and turkey burgers. During interview on 10/21/15, at 9:48 a.m. cook (CK)-A stated raw meats should not be stored on the top shelf because if the container leaks or spills, it would contaminate the other foods, and stated raw meat, "Should be on the bottom [shelf]." CK-A stated she received training when she was hired to work in the kitchen that, "Meat goes on [the] bottom shelf." During interview on 10/21/15, at 10:38 a.m. certified dietary manager (CDM) stated raw meats should be stored on the bottom of the refrigerator and, "Technically anything that's raw should be stored on the bottom." CDM stated if the containers of raw meats were to leak or be knocked over, it could cause spillage onto the other food below it in the refrigerator.	F 371	to ensure raw meat is stored in a safe manner to reduce cross contamination. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The Dietary Manager immediately moved the covered/sealed pan of raw chicken/turkey to the bottom shelf upon surveyor notification of finding on 21 Oct 15. This action was taken per surveyor's recommendation. 2.Actions taken to identify other potential residents having similar occurrences: All residents served out of the main kitchen had the potential to be affected by the issue cited in the statement of deficiencies. 3.Measures put in place to ensure deficient practice does not recur: Refrigerator and Freezer Storage policy was changed to reflect that all raw meats will be stored on bottom shelving 27 Oct 15. The Dietary Manager began educating the Dietary staff on the surveyor's recommendations to store all raw meats on the bottom shelving immediately. All Dietary employees were educated by 11 Nov 15. 4.Effective implementation of actions will be monitored by: The Dietary Manager, or designee, will audit the storage of raw meat in the refrigerators to insure safe practices are followed. Audits will be done weekly for	

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F 371	Continued From page 120 During interview on 10/22/15, at 3:07 p.m. corporate registered dieticians (RD)-A and RD-B stated raw meat should be placed, "Ideally on a bottom shelf," because if it was knocked over or spilled it could contaminate the bagged vegetables and Spanish rice stored below it. RD-A stated raw chicken and turkey could potentially contain bacteria and cause food borne illness if the juices were spilled onto other foods. The facility Refrigerator and Freezer Storage policy dated 11/10/14, identified, "Meats or other raw items are thawed in the bottom of the refrigerator so that melting liquids do not drop onto other foods ... All food items will be stored in a manner to prevent drippings from contaminating other items below."	F 371	one month and then quarterly for six months. 5.Those responsible to maintain compliance will be: The Dietary Manager is responsible for the overall compliance. Completion date for certification purposes only is: November 11, 2015	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon in a timely	F 412	F412-D Facility timely submits this response and plan of correction pursuant to federal and	12/29/15

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F 412	Continued From page 121 manner for 1 for 3 residents (R85) reviewed for dental hygiene and who needed new dentures. Findings include: R85's quarterly Minimum Data Set (MDS) dated 9/1/15, identified R85 had intact cognition. During observation on 10/20/15, at 10:10 a.m. R85 was seated in his room in a wheelchair. R85 had visible missing teeth on his lower palate, and his upper denture moved in his mouth while he spoke. R85 stated his dentures were getting, "Worn down", and were, "Not effective anymore." R85 stated at times he had trouble chewing food because of the loose fitting dentures, and would like to have them looked at by a dentist. R85's Patient Progress Notes dated 8/11/15, identified R85 had been seen by the dentist who visits the facility. The dentist identified, "Pt [patient] has full upper and lower partial. Lower partial denture is not anchored on any teeth as all remaining lower teeth are fractured off at the gumline ... Both full upper and lower partial have extreme occlusial wear, and pt it using adhesive on both for retention. Pt is interested in new upper only ..." The dentist identified a treatment plan of, "Will tx [treat] plan full upper and full lower dentures and if pt decides to proceed, we can refer to an oral surgeon for the extractions of remaining lower teeth [roots]." R85's facility progress notes dated 8/11/15, identified R85, "...was seen by In House Dental ... recommends that resident has all remaining lower roots extracted with an oral surgeon & [and] then have a new full upper and lower denture made ... will discuss these recommendations with	F 412	state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure dental recommendations are acted upon in a timely manner. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident is alert and orientated. Resident signed consent form for facility dental vendor but then chose to go to outside dentist. Social Worker met with Resident 412 to review resident preference for dentures on 26 Oct 15, and an oral consult was completed on 3 Nov 15. Appointment is scheduled with the oral surgeon to proceed with the denture process. 2.Actions taken to identify other potential residents having similar occurrences: Medical records or designee reviewed dental visit log to ensure residents with pending dental needs have follow up plan in place. Modified Resident QIS Interview questionnaire was asked of residents to ensure dental needs are met according to	

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F 412	Continued From page 122 resident and if he chooses will send him out to a consult to pursue..." No further notes were identified in R85's medical record as having the follow up completed for new dentures as requested by R85 and the dentist. During interview on 10/26/15, at 10:05 a.m. registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided.	F 412	resident preference. 3.Measures put in place to ensure deficient practice does not recur: Due to dental vendor not being able to meet resident needs within facility, facility was in transition to a new dental vendor during survey. Facility has implemented IDT stand up meetings starting 30 Dec 15 to monitor for potential dental concerns . MDS Coordinator for the facility will ask oral care questions with RAI reviews and contact social worker or designee if dental needs are required or requested. Staff education will be provided on oral care to be completed by 13 Dec 15. 4.Effective implementation of actions will be monitored by: Dental logs will be reviewed monthly by medical records or designee for one year to ensure timely dental follow up has been completed. Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observation or modified CMS QIS Non-Interviewable Resident Observations and facility will complete five NAR Care Observations weekly for three months. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be:	

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F 412	Continued From page 123	F 412	The Director of Nursing is responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist recommendations to establish pain medication parameters for use were acted upon for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, no pain, and required extensive assistance with his activities of daily livings (ADLs). The MDS identified R5 had diagnoses including chronic osteomyelitis [an infection of the bone or bone marrow] and a non-pressure related foot ulcer.	F 428	F428-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center	12/29/15

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F 428	Continued From page 124 R5's signed Physician Order Report dated 10/6/15, identified medication orders for pain including the following: "Acetaminophen [medication used to treat pain and inflammation] tablet; 650 mg [milligrams] ... DX: [diagnosis] pain ... Every 4 Hours - PRN [as needed]." "Tramadol [narcotic-like pain reliever] - Schedule IV [four] tablet; 50 mg; ... Every 6 Hours - PRN." The signed physician orders did not provide or identify any parameters or direction for when nursing staff should administer the Acetaminophen versus the Tramadol to help control R5's pain. R5's Consultant Pharmacy Drug Regimen Reviews directed the following, "Potential by [sic] insignificant problem," to be acted upon by facility staff: 8/3/15 - " [#5] Please check if there are parameters for using prn Acetaminophen vs [versus] Tramadol?" 9/2/15 - "Repeat MMR [medication regimen review] 8/3/15 #5 - if not addressed." 10/1/15 - "Repeat 8/3/15, MMR #5. Does not appear to be addressed." R5's medical record was reviewed and there was no evidence the consultant pharmacist's recommendations were acted upon as requested on 8/3/15, 9/2/15, and 10/1/15, to assist in clarifying the parameters for R5's pain medication regimen. During interview on 10/26/15, at 9:36 a.m.	F 428	to ensure that pharmacist recommendations to establish pain medication parameters for use are acted upon. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The cited resident is alert and orientated, and was interviewed on 30 Oct 2015. Resident requested that he be allowed to continue to request Tylenol as needed for general discomfort and indicated he no longer wanted Tramadol. The pharmacist recommendation was reviewed and medical provider contacted to discontinue prn Tramadol on 30 Oct 2015 due to non-use. 2.Actions taken to identify other potential residents having similar occurrences: The pharmacy recommendations from the past quarter were reviewed by 29 Dec 2015 to ensure follow up on pharmacy recommendations. Issues noted during the review were corrected for compliance. 3.Measures put in place to ensure deficient practice does not recur: Pharmacy recommendations will be distributed by Director of Nursing to designated nurses for completion. Education was provided on this deficiency and Pharmacy Medication Regimen Reviews that was completed 13 Dec 2015 with licensed staff. Education on Medication Administration was completed by 13 Dec 2015 for licensed staff and	

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F 428	Continued From page 125 licensed practical nurse (LPN)-A stated she would provide either of the medications to R5 based on how much pain he would complain of, however, she stated established parameters would ensure staff were treating R5's pain consistently. LPN-A reviewed R5's EMAR (electronic medical administration record) and stated there were no established parameters for R5's as needed pain medications. During interview on 10/26/15, at 9:54 a.m. registered nurse (RN)-A stated the nursing staff reviews the pharmacists recommendations after each visit and updates the physician with the pharmacy recommendations. RN-A reviewed R5's medical record and stated the recommendation by the pharmacist to establish parameters for R5's as needed pain medications was not addressed, and stated the recommendations should have been followed up on, "That's an issue." During interview on 10/26/15, at 11:14 a.m. the consulting pharmacist (CP) stated he allows facilities a certain time period for staff to address his recommendations, however, the facility should have addressed the recommendations made on 8/3/15, 9/2/15, and 10/1/15, and stated, "It should be done." A facility policy on medication regimen review and management was requested, but none was provided.	F 428	TMAs. 4.Effective implementation of actions will be monitored by: Audits will be completed on 10 residents with pharmacy recommendations monthly to ensure timely follow up for three months by the Director of Nursing, or their designee. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 2015	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		12/29/15

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F 441	Continued From page 126 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement infection	F 441	F441-D Facility timely submits this response and	

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F 441	Continued From page 127 control practices and procedures to prevent the spread of infection for 1 of 3 residents (R118) observed during a wound dressing change. Findings include: R118's undated Resident Admission Record identified diagnoses including cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg with unspecified severity-non-healing, and pseudomonas in wound. R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and required limited assistance for most activities of daily living (ADLs). On 10/22/15, at 10:16 a.m. licensed practical nurse (LPN)-F was observed completing a dressing change to R118's open wound to the right lower leg. LPN-F gathered the necessary supplies, laid a clean towel directly on the floor beneath R118's right foot, while R118 remained seated in her wheelchair. No barrier was placed between the towel and the floor. After washing her hands and applying gloves, LPN-F removed the soiled stockinet (a stretchy fabric used for bandaging), removed the soiled dressing with use of a small scissors, and then removed the absorption pad over the open wound to R118's right lower leg. The dressing and absorption pad were discarded in the trash, but the stockinet and scissors were set aside, while LPN-F proceeded to use Simply Saline Wound Wash to soak and loosen a Silversorb (antimicrobial wound dressing) from R118's open wound. Dark brown debris and slough was observed to break free from the wound and drip onto the towel beneath R118's foot. LPN-F removed the dark brown	F 441	plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Nurse completing the wound care is no longer employed by facility. 2.Actions taken to identify other potential residents having similar occurrences: Residents requiring dressing changes for wound care have the potential to be affected by area cited. 3.Measures put in place to ensure deficient practice does not recur: Education on Infection Prevention and revisions completed with licensed staff by 13 Dec 15. Education content used upon facility orientation and with annual	

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F 441	Continued From page 128 debris away from the wound using the saline wash to break it up and removed it. The saline wash, mixed with debris/ slough, was dripping from R118's right lower leg, onto the towel. The towel was visibly soaked through, in a circular area beneath R118's right heel, approximately six inches in diameter. At 10:27 a.m., LPN-F removed her gloves and washed her hands after cleansing the wound. At 10:29 a.m., LPN-F applied new dressings and a clean stockinet to the wound, then placed R118's foot back onto the footrest of her wheelchair. LPN-F folded the towel inward and draped it over the lined garbage bin. She picked up her supplies and stepped back behind R118, next to the night stand. LPN-F rested the scissors atop a Dycem mat, which covered the top of R118's night stand. No barrier was placed between the scissors and the Dycem mat. She then reached to open one of the night stand drawers. At this time, R118 self-propelled her wheelchair forward approximately 18 inches, so LPN-F could open the drawers and put away her supplies. The right front and back wheels of R118's wheelchair was observed to roll over the area of the floor that became soiled by the soaked towel. Once LPN-F had finished accessing the night stand drawers, R118 self-propelled her wheelchair back through the same area and returned to her original position. At 10:37 a.m., LPN-F retrieved a Clorox disinfectant wipe from her medication/treatment cart and wiped the flooring beneath where the towel was placed, then obtained another sanitizing wipe from her cart and returned to wipe the scissors clean and return it to one of the night stand drawers. LPN-F did not wipe the Dycem mat where she had rested the soiled scissors on R118's night stand. LPN-F stepped away from the area and the original (soiled) stockinet which	F 441	in-services related to Infection Prevention reviewed and revised by 29 Dec 15. 4.Effective implementation of actions will be monitored by: Monitor a random sampling of residents with dressing change treatments five times per month for three months. The data collected on these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Infection Control Coordinator for the facility will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 15	

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F 441	Continued From page 129	F 441		

had been set aside earlier, was draped over a thin metal bar of R118's wheelchair, located behind the right foot rest, near the right front wheel. The stockinet was observed with multiple, circular, light to dark brown spots of dried wound drainage.

During interview on 10/22/15, at 10:51 a.m. LPN-F stated it was her typical practice to use a towel directly on the floor to, "Sop up any fluids that drip to the floor," during R118's wound dressing changes. LPN-F stated she used a Clorox disinfectant wipe to clean the surface of the floor after the dressing change. LPN-F stated she did not realize R118 propelled her wheelchair through the soiled area of the floor before she disinfected it. LPN-F stated when she was cleaning up the supplies R118 removed the stockinet from the soiled linens she had gathered, and it was R118's preference to rinse out her stockinet and re-use them, rather than send them through the laundry. When LPN-F was asked about placing the soiled scissors on top of the Dycem mat on R118's night stand, she stated, "[I] had to put it somewhere..." LPN-F stated she typically tried to keep the scissors apart from her clean dressings and to keep it off of the floor, and LPN-F stated she thought she had wiped the area where she had set the scissors with a sanitizing wipe.

During interview on 10/26/15, at 2:24 p.m. registered nurse (RN)-B, the facility's infection control coordinator, stated disinfectant and sanitizing wipes should have been amongst the supplies LPN-F gathered for R118's dressing change. RN-B stated without a proper barrier beneath the towel, LPN-F should have disinfected the flooring immediately, and if the wheelchair did

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F 441	Continued From page 130 come in contact with the soiled area, it should have been sanitized immediately. RN-B also stated a barrier should have been placed between the soiled scissors and R118's night stand, and the soiled stockinet should have been sent to the laundry and replaced with a clean one. RN-B stated if the material was obviously soiled it needed to go to the laundry for cleaning. The facility's Infection Control Committee- Duties and Responsibilities policy dated 6/14, directed the facility's committee was responsible for developing training programs for all facility personnel on infection control policies and procedures. The committee was also responsible for ensuring the facility maintained a sanitary environment, with all personnel following established infection control procedures and precautions. The facility's training program was to include the use of protective barrier equipment, along with the decontamination and disposal of equipment when exposed to blood/ bodily fluids.	F 441		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration effectively assessed and developed a plan to address the inadequate staffing in the facility as identified	F 490	F490-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response	12/29/15

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F 490	Continued From page 131 during the recertification survey. This had potential to affect all 48 residents residing in the facility. Findings include: > Refer to F353; The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been	F 490	and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15. Facility has developed and implemented action plans for cited deficiencies related to the care and services of residents (Refer to F353). Quality Assessment and Assurance Committee will meet in January to review and revise action plans. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected. 3.Measures put in place to ensure deficient practice does not recur:	

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	245513	A. BUILDING _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(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 490	Continued From page 132 injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed, nor have the administration revised delegations or staff responsibility. During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time." During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing and the cares are not able to be completed. NA-T stated the administration held a meeting a few months ago with all staff and talked about solutions to short staffing, however, nothing had been done to improve the lack of staff to ensure resident cares can be completed, and administration had not followed up regarding what is being done to meet the needs of the residnets. During interview on 10/22/15, at 2:20 p.m. NA-K	F 490	Facility has added a QAPI meeting to be conducted between the quarterly Quality Assessment and Assurance Committee meetings. Action plans will be developed as needed for indicated quality needs as identified at QAPI. Quality Assessment and Assurance Committee will determine compliance regarding action plan areas. IDT was educated on QIS Quality Assessment and Assurance Committee and Staff was educated on the role of Quality Assessment and Assurance Committee by 13 Dec 2015. 4.Effective implementation of actions will be monitored by: Administrator and Quality Assurance and Assessment Committee will monitor action plans and report to corporate for assistance in oversight. Action plans will be monitored for progress towards goals and revised as needed. Quality Assurance and Assessment Committee will determine compliance regarding action plan areas. Administrator will give updates on action plan implementation at Resident Council and staff meetings times for three months. Elim COO, or designee, will monitor Administrators performance monthly for three months to ensure administration has been acting on these concerns identified by staff and residents. 5.Those responsible to maintain compliance will be: Corporate COO or designee is responsible for compliance.	

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F 490	Continued From page 133	F 490		

stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but they expect the floor staff to get the work done and only come onto the floor when you guys [state surveyors] are here."

During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was not being completed as assessed. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked the resigning floor staff's input on how to handle the short staffing situation.

During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in extra staff to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed becasue there was not enough staff to provide the cares, and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed, although DON was aware

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F 490	Continued From page 134	F 490		

there was not enough staff to provide the bathing. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done this week, "Because you guys [state surveyors] are here."

During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix the lack of staffing, and SM-B had heard nothing further on how administration will resolve this.

During interview on 10/26/15, at 5:06 p.m. the DON stated, "Right now we are just stuck on the staffing [lack of]. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing, however, the concern of lack of staff is ongoing. The DON stated facility management had offered hiring bonuses, implemented significant differential pay, and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of summer, when students returned to

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F 490	Continued From page 135 college, as well as eight facility staff who left on maternity leave. The DON confirmed the facility was still accepting new admissions, and stated she was aware of staff concerns of residents who were not receiving baths or oral cares, and, "This is one of the things that is tied to staffing. We are supposed to have a bath aide [but] have not had one since September, I think everybody [residents] is getting really good wash ups." When interviewed on 10/26/15, at 4:24 p.m. the administrator stated staff had voiced concerns to him regarding the lack of staffing and, "They [staff] need more people", to help complete resident cares. The facility staffing was determined based on the size of the building, and if they currently had many residents who required extensive staff assistance for cares. The facility did cut hours if they are down in resident census, and use a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals x amount of dollars." The administrator stated he had "certainly identified there is a problem" with lack of staffing, and the focus was to hire and recruit new staff stating it had been the focus, "For a long time." Further, the administrator stated the facility had "used everything" to recruit more staff, and he felt there was "no stone unturned" in trying to address the issue of the lack of staffing to provide the necessary cares for the residents.	F 490		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		12/29/15

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F 520	Continued From page 136 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility's quality assessment and assurance (QA&A) committee failed to develop and implement action plans to address identified, systematic concerns of inadequate staffing patterns to ensure residents were provided with care and services in accordance with their assessed needs, for 13 of 42 residents (R126, R73, R27, R19, R45, R35. R21, R5, R64, R55, R85, R118 and R123) reviewed for compliance with quality of care and quality of life regulations. This had the potential to affect all 48 residents in the facility.	F 520	F520-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.	

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F 520	Continued From page 137 Findings include: > Refer to F241; The facility failed to ensure timely assistance with toileting aftercares and failed to ensure appropriate incontinence products were provided, for 1 of 2 residents (R126) who expressed concerns of undignified care and services. > Refer to F242; The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. > Refer to F244; The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. > Refer to F282; The facility failed to provide appropriate incontinence products when necessary and failed to ensure appropriate use of a pressure relieving wheelchair cushion, as directed by the written plan of care, for 1 of 4 residents (R126) reviewed for pressure ulcers. The facility also failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. > Refer to F312; The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. > Refer to F353; The facility failed to provide	F 520	It is the policy of Lake Ridge Care Center to have a Quality Assessment and Assurance Committee that develops and implements appropriate plans of action to correct identified quality deficiencies. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15. Facility has developed and implemented action plans for cited deficiencies related to the care and services of residents. Quality Assessment and Assurance Committee will meet in January to review and revise action plans. Cited residents will be invited to the Resident Council meeting on December 8th to review Staffing action plan. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected. 3.Measures put in place to ensure deficient practice does not recur: Action plans will be developed as needed for indicated quality needs as identified at Quality Assessment and Assurance Committee. Quality Assessment and Assurance Committee will determine compliance regarding action plan areas. IDT was educated on QIS QA&A by 13 Dec 2015. Staff was educated on the role of Quality Assessment and Assurance	

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F 520	Continued From page 138 adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. On 10/26/15, at 5:06 p.m. the director of nursing (DON) was interviewed regarding the facility's QA&A committee. The DON reported the QA&A committee gathered data from numerous sources in effort to identify potential quality deficiencies within the facility. Some of those sources included care conference reports, facility concern forms, verbal and/or written reports from staff/ family/ residents, resident satisfaction surveys and the on-going review of audit results, from past survey results or other quality deficiencies the committee had identified. The DON reported that all residents and/or their representatives were asked at each care conference whether the facility was meeting their needs and whether they felt they had been treated well. Any identified concerns were presented to the QA&A committee. When asked to provide an example	F 520	Committee by 13 Dec 2015. 4.Effective implementation of actions will be monitored by: Action plans will be monitored for progress towards goals and revised as needed. Quality Assurance and Assessment Committee will meet quarterly to determine compliance regarding action plan areas. Administrator will monitor Quality Assurance and Assessment Committee action plan. 5.Those responsible to maintain compliance will be: Administrator is responsible for compliance.	

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F 520	Continued From page 139	F 520		

of a quality deficiency the committee had identified, providing a description of any resulting action plans, the DON reported, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "I don't know how to make that a QA thing... We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed the QA&A committee was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. She stated, the facility's QA&A committee had not actually developed or implemented an action plan to address the staffing concerns within the facility. However, she stated, "We report to QA what we have done." The DON stated facility management had offered hiring bonuses, implemented significant differential pay and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of Summer, when students returned to college. She added, there were eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident discharged. When asked whether the facility's QA&A committee had identified or addressed concerns of residents who were not receiving baths or oral cares, she responded, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups."

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F 520	Continued From page 140 A facility policy regarding the responsibilities of the QA&A committee was requested, but was not provided.	F 520		

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F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126,	F 353	F353-F Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the	12/29/15

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

Electronically Signed | 11/27/2015

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F 353	Continued From page 1 R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents who currently resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: > Refer to F241: The facility failed to ensure timely assistance with toileting aftercare's and failed to ensure appropriate incontinence products were provided, for 1 of 2 residents (R126) who expressed concerns of undignified care and services. > Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. > Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. > Refer to F282: The facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. > Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5,	F 353	drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: We have provided written plans of correction for F-tags F-241 for R126, F-242 for R73, F-244 for R27, R19, R45, R35, R21, F-282 for R5 and F-312 for R64, R44 and R19 relating to the care of these cited residents found in the findings of our most recent CMS-2567, and how we have and/or will address those respective issues. We will continue interview, select and train prospective nursing employees as they are available to provide the care needed to these cited residents. 2.Actions taken to identify other potential residents having similar occurrences: All residents had the potential to be affected by these deficient practices. 3.Measures put in place to ensure deficient practice does not recur: Facility Administration met with corporate HR to develop a staffing action plan on 6 Nov 15; corporate HR will perform	

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F 353	Continued From page 2 R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. RESIDENT CONCERNS ABOUT STAFFING: R126's admission Minimum Data Set (MDS) dated 9/29/15, identified R126 had intact cognition, and required extensive assistance to complete ADLs. During interview on 10/22/15, at 3:22 p.m. R126 stated he had to wait up to thirty minutes to have his call light answered to receive assistance with cares. R126 stated he needed staff assistance to use the restroom and get into his wheelchair, and he never knew how long it would take staff to answer his call light and that made him feel, "Anxious," and "Helpless." During a follow-up interview on 10/26/15, at 10:00 a.m. R126 stated his preference was to use a commode for toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He stated, he need help to get on and off the commode, but is unable to get onto the commode alone, and has to wait for staff to help. R126 reported he would have much rather used a commode for toileting and not a bed pan, because he doesn't get as "messy," But staff does not respond to his call light for assistance timely to help onto the commode, so he has to use the bedpan and not the commode, which he prefers to use. R55's quarterly MDS dated 9/15/15, identified	F 353	interviews and assist in hiring until open positions are filled, and selection of new employees will be done within the requirements of employment law. Nursing schedules have been re-created, and are posted for two-week time periods or more, and any vacant positions are posted on the schedule. These vacant hours are available to current employees, and are also called in to a pool agency if they cannot be filled before the pay period begins. Variably, weekly orientations have also been implemented to assist in staff getting onto the floor. Bonuses have been and will continue to be offered to fill vacant shifts, as well as increased night differentials. Advertisements for nurses and nursing assistants have been and will continue to be placed in local papers and online sources, such as Indeed, until open positions are filled. Locations that provide nursing assistant programs have been contacted to let them know of any open positions and how we can partner together to attract more applicants. A suggestion box was put into use to solicit input from employees, as well as using annual reviews and the EQIC meeting to address potential job duty issues. All employees were educated on what we are doing to attract new employees. We are hoping to hire a staffing coordinator to assist in scheduling and shift replacement. To allow for the proper care of our residents, we have also added on a new position, Resident Concierge Representative, to help assist in the needs of our residents.	

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F 353	Continued From page 3 R55 had moderate cognitive impairment, and required limited assistance from staff for ADLs. During interview on 10/20/15, at 9:13 a.m. R55 stated she often had to wait for extend periods of time to get help to the bathroom, and was frequently incontinent because of waiting for so long. R55 stated the facility needed more staff to help residents with their cares, "They just don't have the people to work." R85's quarterly MDS dated 9/1/15, identified R85 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:03 a.m. R85 stated the facility had been, "Short of staff," for the past two or three months. R85 stated staff takes, "Quite awhile" to answer his call light to provide assistance with cares, and it had, "Been a big annoyance." R118's admission MDS dated 8/24/15, identified R118 had intact cognition, and required limited assistance from staff to complete ADLs. During interview on 10/21/15, at 11:34 a.m. R118 stated staffing seems worst on the weekend and in the evenings. R118 had a dressing change that needed to be completed, however, the resident had to wait over 6 hours for staff to complete this which caused the dressing to become saturated and drip fluids. R5's quarterly MDS dated 9/15/15, identified R5 had intact cognition, and required extensive	F 353	4.Effective implementation of actions will be monitored by: Open positions and vacant shifts will be recorded on the schedule and an explanation of how those open positions or vacant shifts were covered will be written in the nursing schedule. If a shift cannot be filled for some reason, the Director of Nursing will be contacted, and that contact, time and vacancy will be written in the nursing schedule book. The Director of Nursing will inform the Administrator weekly for two months of open nursing department positions and shifts unable to be filled and the course of action to fill those positions and shifts, and as needed thereafter. All-staff meetings will be held monthly for three months. Each Employee Quality Improvement Committee meeting will have adequate staffing levels added to the agenda, with reports continuing to be provided to the quarterly Quality Assurance and Assessment Committee, to provide a system of allowing employees to discuss staffing levels to see if they are successful or not; the minutes of those meetings will be posted in the employee lounge. Adequate staffing levels will be on the agenda for each care conference, with attending residents and families being able to comment on whether changes with staffing levels are successful or not. Reports of adequate staffing will be evaluated and PDSA models will be implemented to continuously improve and enhance staffing. This data collected will be presented to the Quality Assessment & Assurance Committee quarterly meeting	

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F 353	Continued From page 4 assistance from staff to complete ADLs. During interview on 10/20/15, at 9:11 a.m. R5 stated the facility did not have enough staff, and staff would often complain about being short staffed to him, and at times R5 had stated there was only one nurse working for an entire shift. R5 stated his call light will take, "Fifteen to twenty minutes," to get answered, and was once left on the commode for, "An hour and a half," before staff came to provide assistance. R73's admission MDS dated 10/1/15, identified R73 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/21/15, at 10:55 a.m. R73 stated he had waited for nearly two hours in the past for staff assistance to go to bed and for his call light to be answered. R73 stated the staff are over worked and under staffed for the residents to be provided the necessary cares in the facility. R35's quarterly MDS dated 10/6/15, identified R35 had moderate cognitive impairment, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:29 a.m. R35 stated the facility staff worked short nearly all of the time, and there had been times R35 would have to wait to use the bathroom but was incontinent due to not receiving timely assistance from staff to get to the restroom. R123's admission MDS dated 10/15/15, identified	F 353	and the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	

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F 353	Continued From page 5 R123 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 12:20 p.m. R123 stated she had waited for over an hour to get help to the restroom, causing her to, "Just use my diaper," which she stated made her, "Feel degraded." R27's quarterly MDS dated 9/22/15, identified R27 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:24 a.m. R27 stated she had waited for over an hour to have her call light answered to receive assistance, and the facility needed to have more staff to provide the cares the residents needed. FAMILY COMPLAINT'S ABOUT STAFFING: During interview on 10/21/15, at 11:31 a.m. family member (FM)-G stated they had visited their family member in the past and used the call light requesting staff assistance and "Waited, and waited, and waited," over twenty five minutes for staff to respond. There had been multiple occurrences of waiting for the call light to be answered, and FM-G stated, "It [long call light response times] concerns me." FM-G stated they had been told the owners of the facility felt they were "Adequately staffed," but stated she disagreed and the facility needed to add more staff to help residents with cares. During interview on 10/26/15, at 10:01 a.m. FM-H stated he had noticed oral cares were frequently	F 353		

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not being completed because of the lack of staff at the facility. The call light had taken over one hour to be answered in the past, and was especially worse on the weekends.

STAFF CONCERNS ABOUT STAFFING:

During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed.

During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time."

During interview on 10/22/15, at 1:23 p.m. NA-I stated the staffing at the facility was, "Not good,"

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and there was frequently only one or two NA's on each hallway to provide cares to the residents. The residents frequently had to wait, and call lights were not answered timely because of the lack of staffing, "They [residents] don't get the care they should get." NA-I stated several staff members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves.

During interview on 10/22/15, at 1:36 p.m. NA-C stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff.

During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing. NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed.

During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K

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stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but "they expect" the floor staff to get the work done and only come onto the floor, "When you guys [state surveyors] are here."

During interview on 10/22/15, at 2:53 p.m. licensed practical nurse (LPN)-F stated staffing is "Not adequate," to care for the residents and their needs, and she was quitting her position at the facility because she valued her nursing license, and felt it was being put in jeopardy because of the lack of staffing and poor care being delivered as a result.

During interview on 10/23/15, at 7:07 a.m. LPN-B stated she felt the facility did not have enough staff to provide the necessary care to residents, and residents had to wait to get up for the day, and families voice frustration to the staff regarding the suffering care as a result of the poor staffing. LPN-B stated she recalled some dressing changes weren't completed because the nurse did not have time because they were busy trying to help provide the necessary care for the other residents.

During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was suffering overall. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked for floor

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staff's input on how to handle the short staffing situation.

During interview on 10/26/15, at 2:32 p.m. occupational therapist (OT)-K and occupational therapist assistance (OTA)-J stated the floor staff could use more help, and the biggest complaint they hear from residents was the lack of staffing and waiting, "Way too long for [call] lights," to be answered. OT-K and OTA-J stated they were not aware of any actions being taken by the facility to address the short staffing concerns.

During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in people to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done, "because you guys [state surveyors] are here."

During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not

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having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix this.

The facility LRCC (Lake Ridge Care Center) documents, which displayed the names of the staff working on the floor for each shift, dated 10/19/15, to 10/23/15, were reviewed. The document identified each unit of the facility (Oasis, Lake View Lane, Mill Creek Bridge, and Northwoods), and provided blank spaces in which a staff members name was written to identify were they were scheduled to work.

> On the AM shift, 10/19/15, the Oasis unit had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods each had open spaces identifying no staff were scheduled to work; and were left with just one nurse and one NA for each unit. The document identified six of the thirteen spaces used to identify staff, to be blank.

> On the AM shift, 10/20/15, the Oasis unit again had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods had open spaces with no staff names written in. Both units continued with just one nurse, and one NA working on the floor providing care for the residents. The document identified six of the thirteen spaces used to identify staff, to be blank.

> On the AM shift, 10/21/15, the Mill Creek Bridge had no NA displayed, only having a nurse assigned to provide care to the residents. Northwoods had one nurse and one NA to provide cares to the residents. The document identified seven of the thirteen spaces used to

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F 353	Continued From page 11 identify staff, to be blank. > On the AM shift, 10/22/15, the Lake View Lane had no nurse identified, and only one NA. Mill Creek Bridge and Northwoods again each only had one nurse and one NA identified as providing cares. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/23/15, the Oasis unit had no staff name identified as being assigned to work on the unit, and the Lake View Lane did not have a nurse identified. The document identified five of the thirteen spaces used to identify staff, to be blank. On 10/26/15, at 5:06 p.m. the director of nursing (DON) stated, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON stated the facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. DON stated the facility's staffing shortage began around the end of summer when students returned to college, and there were also eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident was discharged. When asked whether the facility had identified or addressed concerns of residents who	F 353		

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F 353	Continued From page 12 were not receiving baths or oral cares, DON stated, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD** **BUFFALO, MN 55313**

(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 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 22, 2015. At the time of this survey, Building 01 of Lake Ridge Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/27/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD BUFFALO, MN 55313**

(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	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility will be surveyed as two separate buildings. Lake Ridge Care Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1976, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is now partially sprinklered based on the K56 tag. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 47 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD BUFFALO, MN 55313**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and an interview with staff it was determined that the automatic fire sprinkler system has not been installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow a fire to progress throughout the building and negatively effect all patients, the staff and any guests of the facility. Findings include: On facility tour between between 8:30 AM and 12:00 PM on 10/22/2015, observations and an interview with the Director of Maintenance	K 056	K-056 (F) Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.	12/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD** **BUFFALO, MN 55313**

(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 056	Continued From page 3 revealed that: 1. In the 1960 Addition, the resident rooms # 103 through # 116 closets were found not to be sprinklered 2. In the 1976 Addition, the resident rooms # 117 through # 135 double closets were found to be sprinklered only on one side. These closets are separated by a solid set of drawers from floor to ceiling creating an obstruction. These deficient practices were confirmed by the Director of Maintenance (BT) at the time of the inspection.	K 056	It is the policy of Lake Ridge Care Center to insure the entire building is fully sprinkled. To assure continued compliance, the following plan has been put into place; 1. Description of what has been done, or will be, done to correct the deficiency: Sprinklers have been installed in all the areas, noted in the deficiency that did not have sprinklers. 2.The actual, or proposed, completion date: The sprinklers will be completed on 1 Dec 2015. 3.The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency: The Environmental Services Director will be responsible to prevent a reoccurrence of the deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **02 - OASIS** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD BUFFALO, MN 55313**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lake Ridge Care Center, Oasis wing (2014 addition) 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility will be surveyed as two separate buildings. Lake Ridge Care Center Oasis Wing is a 1-story building built in 2014 and was determined to be of Type 11 (111) construction. The building is fully sprinkled protected. The facility has a fire alarm system with smoke detection in resident rooms, 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 47 at the time of the survey.	K 000	EPOC	

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

Electronically Signed | 11/27/2015

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

Minnesota Department of Health

Electronically delivered
November 19, 2015

Mr. Jason Nelson, Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5513025, H5513019

Dear Mr. Nelson:

The above facility was surveyed on October 19, 2015 through October 26, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5513019. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Brenda Fischer at (320) 223-7338 or email: brenda.fischer@state.mn.us.**

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 19th, 20th, 21st, 22nd, 23rd and 26th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, a complaint investigation was completed for H5513019 and substantiated. 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,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration effectively assessed and developed a plan to address the inadequate staffing in the facility as identified during the recertification survey. This had potential to affect all 48 residents residing in the facility. Findings include: Refer to F353; The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing	2 130	Corrected.	12/29/15

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2 130	Continued From page 3 choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and visitors in the facility. During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed, nor have the administration revised delegations or staff responsibility. During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff	2 130		

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2 130	Continued From page 4 had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time." During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing and the cares are not able to be completed. NA-T stated the administration held a meeting a few months ago with all staff and talked about solutions to short staffing, however, nothing had been done to improve the lack of staff to ensure resident cares can be completed, and administration had not followed up regarding what is being done to meet the needs of the residnets. During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but they expect the floor staff to get the work done and only come onto the floor when you guys [state surveyors] are here." During interview on 10/23/15, at 11:52 a.m.	2 130		

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2 130	Continued From page 5	2 130		

registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was not being completed as assessed. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked the resigning floor staff's input on how to handle the short staffing situation.

During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in extra staff to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed becasue there was not enough staff to provide the cares, and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed, although DON was aware there was not enough staff to provide the bathing. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done this week, "Because you guys [state surveyors] are here."

During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting,

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2 130	Continued From page 6	2 130		

baths, and grooming because of the lack of staff, however, nothing had been done to fix the lack of staffing, and SM-B had heard nothing further on how administration will resolve this.

On 10/26/15, at 5:06 p.m. DON stated, "Right now we are just stuck on the staffing [lack of]. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing, however, the concern of lack of staff is ongoing. The DON stated facility management had offered hiring bonuses, implemented significant differential pay, and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of summer, when students returned to college, as well as eight facility staff who left on maternity leave. The DON confirmed the facility was still accepting new admissions, and stated she was aware of staff concerns of residents who were not receiving baths or oral cares, and, "This is one of the things that is tied to staffing. We are supposed to have a bath aide [but] have not had one since September, I think everybody [residents] is getting really good wash ups."

When interviewed on 10/26/15, at 4:24 p.m. the administrator stated the staffing was determined based on the size of the building, and if they currently had many residents who required extensive staff assistance for cares. The facility

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2 130	Continued From page 7 did cut hours if they are down in resident census, and use a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals x amount of dollars." The administrator stated he had "certainly identified there is a problem" with lack of staffing, and the focus was to hire and recruit new staff stating it had been the focus, "For a long time." Further, the administrator stated the facility had "used everything" to recruit more staff, and he felt there was "no stone unturned" in trying to address the issue of the lack of staffing to provide the necessary cares for the residents. SUGGESTED METHOD OF CORRECTION: The facility administrator and/or their designee, could review and/or revise facility policies and procedures related to effective management and administration. Responsible personnel could be re-educated on these policies and procedures. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 130		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement	2 255		12/29/15

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2 255	Continued From page 8 appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility's quality assessment and assurance (QA&A) committee failed to develop and implement action plans to address identified, systematic concerns of inadequate staffing patterns to ensure residents were provided with care and services in accordance with their assessed needs, for 13 of 42 residents (R126, R73, R27, R19, R45, R35. R21, R5, R64, R55, R85, R118 and R123) reviewed for compliance with quality of care and quality of life regulations. This had the potential to affect all 48 residents in the facility. Findings include: *Refer to F241: The facility failed to ensure timely assistance with toileting aftercares and failed to ensure appropriate incontinence products were provided, for 1 of 2 residents (R126) who expressed concerns of undignified care and services. *Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. *Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council	2 255	Corrected.	

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2 255	Continued From page 9 meetings from 7/28/15 to 9/29/15. *Refer to F282: The facility failed to provide appropriate incontinence products when necessary and failed to ensure appropriate use of a pressure relieving wheelchair cushion, as directed by the written plan of care, for 1 of 4 residents (R126) reviewed for pressure ulcers. The facility also failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. *Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. *Refer to F353: The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, for 1 of 4 residents (R126) reviewed for pressure ulcers, for 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents, staff and	2 255		

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2 255	Continued From page 10 visitors in the facility. On 10/26/15, at 5:06 p.m. the director of nursing (DON) was interviewed regarding the facility's QA&A committee. The DON reported the QA&A committee gathered data from numerous sources in effort to identify potential quality deficiencies within the facility. Some of those sources included care conference reports, facility concern forms, verbal and/or written reports from staff/ family/ residents, resident satisfaction surveys and the on-going review of audit results, from past survey results or other quality deficiencies the committee had identified. The DON reported that all residents and/or their representatives were asked at each care conference whether the facility was meeting their needs and whether they felt they had been treated well. Any identified concerns were presented to the QA&A committee. When asked to provide an example of a quality deficiency the committee had identified, providing a description of any resulting action plans, the DON reported, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "I don't know how to make that a QA thing... We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON confirmed the QA&A committee was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. She stated, the facility's QA&A committee had not actually developed or implemented an action plan to address the staffing concerns within the facility. However, she stated, "We report to QA what we have done." The DON stated facility	2 255		

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2 255	Continued From page 11 management had offered hiring bonuses, implemented significant differential pay and tried to be flexible with shift preferences. She stated the facility's staffing shortage began around the end of Summer, when students returned to college. She added, there were eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident discharged. When asked whether the facility's QA&A committee had identified or addressed concerns of residents who were not receiving baths or oral cares, she responded, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." A facility policy regarding the responsibilities of the QA&A committee was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The medical director, facility administrator and/or director of nursing could review and/or revise facility policies and procedures related to the responsibilities of the Quality Assessment & Assurance committee. Responsible personnel could be re-educated on these policies and procedures. Identified quality deficiencies could be prioritized and evaluated for action plans. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 255		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status	2 265		12/29/15

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2 265	Continued From page 12 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 residents	2 265	Corrected.	

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2 265	Continued From page 13 (R118) who expressed concerns of unmanaged pain and 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118 had no cognitive impairment, required assistance to complete most activities of daily living (ADLs), did not receive scheduled pain medications, however, received as needed (PRN) pain medication and non-pharmacological interventions to manage pain. The MDS also identified the pain made it difficult to sleep at night, and limited her day to day activity, was frequent, and one arterial or venous ulcer. R118's pain Care Area Assessment (CAA) dated 8/24/15, identified R118 had a stasis ulcer on her right leg that was infected and continued to drain large amounts of fluid. The assessment indicated, "Staff will continue to monitor for pain and update MD [medical doctor] as needed." During observation and interview on 10/21/15, at 11:30 a.m. R118 was rubbing her right lower leg, and applying an ice pack to the same area. R118 complained of unmanaged pain related to an open sore to her right, lower leg stating she had just had a routine dressing change completed to the area, and the pain during these dressing changes, "Hits over a 10" on a zero (0) to 10, numeric pain rating scale (0 = no pain, 10 = the most intense pain imaginable). R118 stated she was treated with pain medication prior to having the dressing changed only, "If we [staff and her] think of it." On 10/22/15, at 9:28 a.m. R118 was observed in	2 265		

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her room, receiving her morning medications from licensed practical nurse (LPN)-F. Both LPN-F and R118 confirmed she had just received a pain medication (Gabapentin 300 mg, pain medication to treat nerve pain) and she typically liked to wait "for her pain pill to kick in," before her dressing change was completed. R118 asked LPN-F to return in a half hour to complete her dressing change and to bring an ice pack. At 10:01 a.m., R118 stated, "[Her pain medication] never quite cuts it... when they start scraping, there's nothing [that could stop the pain]." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m. LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she

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2 265	Continued From page 15	2 265		

held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, it's starting to burn." LPN-F asked R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated, "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118.

During interview on 10/22/15, at 10:51 a.m. LPN-F stated R118 had verbal and non-verbal pain indicators during the dressing change, was typical for her. LPN-F stated R118's doctor and nurse practitioner were aware of R118's pain, and R118's pain management regimen consisted of

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2 265	Continued From page 16	2 265		

offering Ultram (an analgesic medication) first, then oxycodone (a narcotic pain medication) if the Ultram was not effective. LPN-F stated the resident could also have ice at any time to help relieve the pain. LPN-F stated she was not aware of any changes in R118's pain medication, and was not sure if anyone had discussed a change in medication with R118's physician.

R118's physician progress notes from 8/17/15, to 10/26/15, included the following:

R118's New Patient History and Physical Examination, completed by medical doctor (MD)-A dated 9/3/15, indicated the resident had osteoarthritis affecting her knees, shoulder, and hip, with residual pain post knee and hip arthroplasties. The report did not further address her pain.

On 8/24/15, nurse practitioner (NP)-A noted R118 had complaints of pain to her right lower extremity with dressing changes.
On 9/10/15, NP-A noted the appearance of R118's right lower leg and reviewed the dressing treatments. NP-A noted, "Discussed pain control will add oxycodone for mod [moderate]/severe pain."
On 9/23/15, a Wound Care/ Hyperbaric Medicine History and Physical noted, there was a wound on the anteromedial portion of (R118's) right lower leg that measured 11 x (by) 12.5 0.1 cm (centimeters) and was very tender to touch. They initially tried to dress the wound with Medihoney; however, the patient developed a lot of discomfort with this. R118 was given a oxycodone and once her pain got better her wound was then dressed.
On 10/8/15, NP-A addressed R118's chronic right lower leg ulcer. NP-A noted, "Resident today says, 'I'm ok,' but frowning and awaiting R [right]

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2 265	Continued From page 17 LE [lower extremity] dressing [change]. C/o [Complains of] pain to R LE. On 10/19/15, NP-A noted R118's emergency room visit was reviewed. The note did not address R118's stasis ulcer. Review of R118's current physician orders dated 10/26/15, directed the following wound treatment and pain management regimen: ·Wound treatment to stasis ulceration on right lower extremity- cleanse wound, and change dressing daily and PRN. ·Gabapentin 300 milligrams (mg), twice daily for peripheral neuropathy/ polyneuropathy. ·Ultram 50 mg, every four hours PRN for pain, for chronic pain syndrome. ·Oxycodone 5 mg, every four hours PRN for pain not relieved by Ultram, for chronic pain syndrome. Review of R118's Electronic Medication Administration Record (EMAR) from 9/1/15, to 10/25/15, identified the following as PRN pain medications were administered for right, lower extremity and leg pain. The September 2015 EMAR identified R118 took a total of 103 doses of PRN pain medication. She took 68 doses of Ultram 50mg, which were effective 42 of 68 opportunities; slightly effective 14 of 68; not effective 2 of 68, and other, which was not identified for 1 of 68 opportunities. R118 had 35 doses of PRN oxycodone 5mg in September 2015, which was effective 14 out of 35 opportunities; slightly effective 3 out of 35; and other which was not identified 3 out of 35, opportunities. The October 2015 EMAR identified R118 was administered 100 doses of pain medication for	2 265		

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LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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2 265	Continued From page 18	2 265		

right, lower extremity leg pain. She took 49 doses of Ultram 50mg, which was effective 18 out of 49 opportunities; slightly effective 17 out of 49; and not effective 6 out of 49 opportunities.

R118 had 51 doses of PRN oxycodone 5mg, in October 2015 which was effective 34 out of 51 opportunities; slightly effective 11 out of 51; not effective 5 out of 51 and other, which was not identified, 1 out of 51 opportunities.

Review of the EMAR PRN administration times from September to October 2015, did not correlate with R118's dressing changes, because the dressing changes were not consistently documented.

Even though R118 was administered 203 doses of PRN pain medication, taken in 55 days, approximately 3.7 doses of PRN pain medication each day, along with her scheduled Gabapentin 300 mg twice a day. R118 continued to experience significant pain with her dressing changes.

Review of R118's nursing progress notes from 9/6/15 through 10/17/15, included the following potential indicators of poor pain control:
On 9/7/15, at 1:39 p.m. registered nurse (RN)-C noted, "[R118] refused to have dressing put on in fear that it would start hurting again... [R118] is leaving it open to air. PRN given."
On 9/8/15, 11:10 p.m. LPN-C noted, "[R118] c/o pain to RLE. [R118] is unable to have any more prn pain medication for another 2 [two] hours. On call physician... said to use standing order of Tylenol. Will administer Tylenol and continue to monitor."
On 9/19/15, at 1:12 a.m. LPN- D noted, "[R118] c/o 7/10 pain right lower extremity; somewhat

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relieved with prn tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]."
On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, 'It burns so bad when drainage is left on my leg.'"
On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds were given closer together."
On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication."

During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's physician was at the facility every Thursday and he was responsible for monitoring to ensure her pain management regimen was sufficiently effective. When asked when the last time was that R118's physician was updated on and/or addressed R118's pain management, RN-H confirmed the most recent notation of the physician/ nurse practitioner having commented on her pain in physician progress notes, was on 10/8/15. RN-H stated that she was aware R118 had significant pain with dressing changes, but believed the current pain management regimen was effective for her. RN-H denied any reports of pain management concerns for R118, from the facility nurses or NAs and would expected her staff would have updated the physician if/when they identified unmanaged pain, to makes changes to her pain regime.

R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily.

Lake Ridge Care Center signed Physician Order

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2 265	Continued From page 20 Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. An Allina Health office visit note dated 4/20/15, indicated under "Your Plan" back on lantus 37 units at bedtime. R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in morning with a start date of 4/17/15 and Lantus at HS (at bed time), with a start date of 4/20/15. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15 to 4/26/15. The Buffalo Clinic Telephone order report dated 4/8/15, indicated at 8:58 a.m. received call from Lake Ridge care center, had blood sugar of 67 today, and told per orders to call if below 80. Per the Buffalo Clinic Telephone order report dated 4/27/15, Dr. Anderson indicated at 5:34 p.m., "Discussed with (staff) by phone. As of 4/20/15 visit, had written to return to Lantus 37 units at bedtime when it should have been once daily MORNING DOSE> Clarified with (staff) patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." Dr. Anderson then ordered Lantus 37 units once daily in the morning as prior to hospital stay. Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45 blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/25/15, indicated a blood sugar was only 51 while R45 was eating	2 265		

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her breakfast meal. Review of the medical record did not indicate the physician was notified of the low blood sugar.

Resident Progress Note dated 4/26/15, at 3:30 a.m. blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood glucose.

Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated "Resident had low BS (blood sugar) this morning was sweating and shaky. she had a BS of 38. The physician was called at 8:44 a.m."

Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated "Resident had been receiving Lantus 37 units BID (twice a day) since 4/20, miscommunication written upon return from appointment. Spoke with Dr. Anderson and the HS dose has been d/c'd (discontinued) and will continue the 37 units in AM."

During interview 10/26/15, at 9:30 a.m. with the DON who stated she was not aware of the insulin discrepancy and stated she was unable to locate a medication error. The DON further stated the nurses should have called the physician when they noted the order for Lantus to be given at HS since she was not on that before and because of her low blood sugars.

Although R45 had an order to notify the physician if blood sugars were below 80, the facility did not notify the physician of the three low blood sugars.

The facility's Change in Resident's Condition Or Status policy dated 7/14, directed "POLICY: It is the policy of Elim Care, Inc. to promptly notify the resident, his or her Attending Physician, and

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2 265	Continued From page 22 representatives of changes in the resident's medical/mental condition and/or status." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to physician notification. Responsible personnel could be re-educated on these policies and procedures. Appropriate notices could be made to the physician's of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate physician notifications. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 265		
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 provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene.	2 565	Corrected.	12/29/15

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2 565	Continued From page 23 Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance with personal hygiene, including brushing his teeth. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room, and showed he had several missing teeth on his upper palate when asked about his oral health. R5's care plan dated 7/14/15, identified R5 had an, "Alteration in ADLs [activities of daily living] of dressing, grooming and bathing...". Further, the care plan directed staff to assist R5 with, "Oral care am [morning] and pm [evening]..." During interview on 10/23/15, at 12:55 p.m. NA-F stated the care plan is used to know "what we're [staff] supposed to do" for the residents care. NA-F helped R5 get ready for the day, but did not offer or assist him to complete oral cares. Further, NA-F stated she should make sure R5 is having his teeth brushed and cleaned so R5 doesn't develop oral disease, or loose additional teeth. When interviewed on 10/23/15, at 1:04 p.m. RN-A stated R5 needs to be set up with assistance to complete oral cares, and NA-F should have offered his oral cares, "That's what should be happening." A facility policy regarding care plan implementation was requested, but was not provided. SUGGESTED METHOD OF CORRECTION:	2 565		

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2 565	Continued From page 24 The director of nursing or designee, could review and/or revise facility policies and procedures related to implementation of resident care plans. Responsible personnel could be re-educated on these policies and procedures. Care and services for the individual(s) identified in the deficiency could be monitored for compliance with their written plan of care. Other residents could be evaluated for care plan implementation. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for	2 800	Corrected.	12/29/15

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2 800	Continued From page 25 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents who currently resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: *Refer to F241: The facility failed to ensure timely assistance with toileting aftercare's and failed to ensure appropriate incontinence products were provided, for 1 of 2 residents (R126) who expressed concerns of undignified care and services. *Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. *Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. *Refer to F282: The facility failed to provide oral	2 800		

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2 800	Continued From page 26 cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. *Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. RESIDENT CONCERNS ABOUT STAFFING: R126's admission Minimum Data Set (MDS) dated 9/29/15, identified R126 had intact cognition, and required extensive assistance to complete ADLs. During interview on 10/22/15, at 3:22 p.m. R126 stated he had to wait up to thirty minutes to have his call light answered to receive assistance with cares. R126 stated he needed staff assistance to use the restroom and get into his wheelchair, and he never knew how long it would take staff to answer his call light and that made him feel, "Anxious," and "Helpless." During a follow-up interview on 10/26/15, at 10:00 a.m. R126 stated his preference was to use a commode for toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He stated, he need help to get on and off the commode, but is unable to get onto the commode alone, and has to wait for staff to help. R126 reported he would have much rather used a commode for toileting and not a bed pan, because he doesn't get as "messy," But staff does not respond to his call light for assistance timely to help onto the commode, so he has to use the bedpan and not the commode, which he prefers to use.	2 800		

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2 800	Continued From page 27 R55's quarterly MDS dated 9/15/15, identified R55 had moderate cognitive impairment, and required limited assistance from staff for ADLs. During interview on 10/20/15, at 9:13 a.m. R55 stated she often had to wait for extend periods of time to get help to the bathroom, and was frequently incontinent because of waiting for so long. R55 stated the facility needed more staff to help residents with their cares, "They just don't have the people to work." R85's quarterly MDS dated 9/1/15, identified R85 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:03 a.m. R85 stated the facility had been, "Short of staff," for the past two or three months. R85 stated staff takes, "Quite awhile" to answer his call light to provide assistance with cares, and it had, "Been a big annoyance." R118's admission MDS dated 8/24/15, identified R118 had intact cognition, and required limited assistance from staff to complete ADLs. During interview on 10/21/15, at 11:34 a.m. R118 stated staffing seems worst on the weekend and in the evenings. R118 had a dressing change that needed to be completed, however, the resident had to wait over 6 hours for staff to complete this which caused the dressing to become saturated and drip fluids.	2 800		

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2 800	Continued From page 28 R5's quarterly MDS dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 9:11 a.m. R5 stated the facility did not have enough staff, and staff would often complain about being short staffed to him, and at times R5 had stated there was only one nurse working for an entire shift. R5 stated his call light will take, "Fifteen to twenty minutes," to get answered, and was once left on the commode for, "An hour and a half," before staff came to provide assistance. R73's admission MDS dated 10/1/15, identified R73 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/21/15, at 10:55 a.m. R73 stated he had waited for nearly two hours in the past for staff assistance to go to bed and for his call light to be answered. R73 stated the staff are over worked and under staffed for the residents to be provided the necessary cares in the facility. R35's quarterly MDS dated 10/6/15, identified R35 had moderate cognitive impairment, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:29 a.m. R35 stated the facility staff worked short nearly all of the time, and there had been times R35 would have to wait to use the bathroom but was incontinent due to not receiving timely assistance from staff to get to the restroom.	2 800		

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2 800	Continued From page 29 R123's admission MDS dated 10/15/15, identified R123 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 12:20 p.m. R123 stated she had waited for over an hour to get help to the restroom, causing her to, "Just use my diaper," which she stated made her, "Feel degraded." R27's quarterly MDS dated 9/22/15, identified R27 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:24 a.m. R27 stated she had waited for over an hour to have her call light answered to receive assistance, and the facility needed to have more staff to provide the cares the residents needed. FAMILY COMPLAINT'S ABOUT STAFFING: During interview on 10/21/15, at 11:31 a.m. family member (FM)-G stated they had visited their family member in the past and used the call light requesting staff assistance and "Waited, and waited, and waited," over twenty five minutes for staff to respond. There had been multiple occurrences of waiting for the call light to be answered, and FM-G stated, "It [long call light response times] concerns me." FM-G stated they had been told the owners of the facility felt they were "Adequately staffed," but stated she disagreed and the facility needed to add more staff to help residents with cares. During interview on 10/26/15, at 10:01 a.m. FM-H stated he had noticed oral cares were frequently	2 800		

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not being completed because of the lack of staff at the facility. The call light had taken over one hour to be answered in the past, and was especially worse on the weekends.

STAFF CONCERNS ABOUT STAFFING:

During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed.

During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time."

During interview on 10/22/15, at 1:23 p.m. NA-I stated the staffing at the facility was, "Not good," and there was frequently only one or two NA's on

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LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 31	2 800		

each hallway to provide cares to the residents. The residents frequently had to wait, and call lights were not answered timely because of the lack of staffing, "They [residents] don't get the care they should get." NA-I stated several staff members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves.

During interview on 10/22/15, at 1:36 p.m. NA-C stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff.

During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing. NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed.

During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit),

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2 800	Continued From page 32 and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but "they expect" the floor staff to get the work done and only come onto the floor, "When you guys [state surveyors] are here." During interview on 10/22/15, at 2:53 p.m. licensed practical nurse (LPN)-F stated staffing is "Not adequate," to care for the residents and their needs, and she was quitting her position at the facility because she valued her nursing license, and felt it was being put in jeopardy because of the lack of staffing and poor care being delivered as a result. During interview on 10/23/15, at 7:07 a.m. LPN-B stated she felt the facility did not have enough staff to provide the necessary care to residents, and residents had to wait to get up for the day, and families voice frustration to the staff regarding the suffering care as a result of the poor staffing. LPN-B stated she recalled some dressing changes weren't completed because the nurse did not have time because they were busy trying to help provide the necessary care for the other residents. During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was suffering overall. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked for floor staff's input on how to handle the short staffing situation.	2 800		

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2 800	Continued From page 33 During interview on 10/26/15, at 2:32 p.m. occupational therapist (OT)-K and occupational therapist assistance (OTA)-J stated the floor staff could use more help, and the biggest complaint they hear from residents was the lack of staffing and waiting, "Way too long for [call] lights," to be answered. OT-K and OTA-J stated they were not aware of any actions being taken by the facility to address the short staffing concerns. During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in people to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done, "because you guys [state surveyors] are here." During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix this.	2 800		

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2 800	Continued From page 34 The facility LRCC (Lake Ridge Care Center) documents, which displayed the names of the staff working on the floor for each shift, dated 10/19/15, to 10/23/15, were reviewed. The document identified each unit of the facility (Oasis, Lake View Lane, Mill Creek Bridge, and Northwoods), and provided blank spaces in which a staff members name was written to identify were they were scheduled to work. > On the AM shift, 10/19/15, the Oasis unit had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods each had open spaces identifying no staff were scheduled to work; and were left with just one nurse and one NA for each unit. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/20/15, the Oasis unit again had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods had open spaces with no staff names written in. Both units continued with just one nurse, and one NA working on the floor providing care for the residents. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/21/15, the Mill Creek Bridge had no NA displayed, only having a nurse assigned to provide care to the residents. Northwoods had one nurse and one NA to provide cares to the residents. The document identified seven of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/22/15, the Lake View Lane had no nurse identified, and only one NA. Mill Creek Bridge and Northwoods again each only	2 800		

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2 800	Continued From page 35 had one nurse and one NA identified as providing cares. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/23/15, the Oasis unit had no staff name identified as being assigned to work on the unit, and the Lake View Lane did not have a nurse identified. The document identified five of the thirteen spaces used to identify staff, to be blank. On 10/26/15, at 5:06 p.m. the director of nursing (DON) stated, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON stated the facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. DON stated the facility's staffing shortage began around the end of summer when students returned to college, and there were also eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident was discharged. When asked whether the facility had identified or addressed concerns of residents who were not receiving baths or oral cares, DON stated, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really	2 800		

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2 800	Continued From page 36 good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from residents, employees and families. Interventions could be identified and implemented to remedy the insufficiencies identified, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		

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2 830	Continued From page 37	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce pain for 1 of 3 residents (R118) reviewed for pain. R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change which resulted in actual harm. The facility also failed to provide proper wheelchair positioning for 1 of 1 residents (R57) who was leaning significantly to the right side. Findings include: PAIN R118's undated Resident Admission Record identified diagnoses including peripheral vascular disease (PVD), osteoarthritis in right hip, cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg non-healing with an	2 830	Corrected.	12/29/15

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2 830	Continued From page 38 infection, chronic pain syndrome, and Trigeminal Neuralgia (nerve pain). The admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and she required limited assistance for most activities of daily living (ADLs). The MDS identified R118 did not receive scheduled pain medication, but received as needed (PRN) pain medication and non-pharmacological interventions for pain management. The MDS identified the pain made it difficult to sleep at night, and limed her day to day activity. A self-reported numerical pain rating scale identified her current pain was a nine out of 10 (a zero (0) to 10, numeric pain rating scale of 0 = no pain, 10 = the most intense pain imaginable). Her pain was identified as frequent, but did not include a verbal description of the pain even though the MDS identified she had one arterial or venous ulcer at the time of the MDS. The Care Area Assessment (CAA) dated 8/24/15, identified R118 needed assistance with all ADLs due to weakness and decreased mobility from osteoarthritis, but wanted to do as much for herself as possible. The CAA identified R118 had a stasis ulcer on her right leg that was infected and continued to drain large amounts of fluid. The CAA identified R118, "Is complaining of pain due to neuropathy, osteoarthritis, and stasis ulcer on right lower leg. States that PRN Tramadol [Ultram, an analgesic medication] relieves pain. Also uses warm towels and repositioning. Staff will continue to monitor for pain and update MD [medical doctor] as needed." Although the MDS identified R118 had pain, which made it difficult to sleep, and limited her day to day activity, the facility had not assessed this area to determine if the pain regime was	2 830		

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2 830	Continued From page 39 appropriate for R118. The care plan dated 10/9/15, identified R118 was at risk for uncontrolled pain related to osteoarthritis and stasis ulcer to her right lower extremity. The care plan goal was for R118 to state her pain was decreased with the use of an analgesic, or show non-verbal signs of decreased pain. Interventions included the following: ·Encourage R118 to report pain levels PRN, per a numeric scale as able. ·Administer medications to R118, routine and PRN, as ordered for pain. ·Monitor R118 for changes in comfort PRN, reassessing her pain as needed. ·Offer R118 comfort measures PRN, of repositioning, heat, cold, massage, diversional activities, etc... During observation and interview on 10/21/15, at 11:30 a.m. R118 complained of unmanaged pain related to an open sore to her right, lower leg. She stated a routine dressing change had just been completed to her right leg and reported the pain she experienced during these dressing changes was excessive, stating her pain "hits over a 10." R118 stated if the nurses think of giving her pain medication before and after the dressing change they will, along with some ice. The ice packs, and pain medication at times, "Will subside almost, and then all of the sudden it is like a grabbing pain that almost sends me through the ceiling." During this conversation, R118 was frequently rubbing her right, lower leg and applying ice packs to the area. R118 stated her current pain level was,"down to a five [5] ... it is tolerable." R118 reported a pain rating of 5 was an acceptable level of pain for her. On 10/22/15, at 9:28 a.m. R118 was observed in	2 830		

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2 830	Continued From page 40	2 830		

her room, receiving her morning medications from licensed practical nurse (LPN)-F. Both LPN-F and R118 confirmed she had just received a pain medication (Gabapentin 300 mg, pain medication to treat nerve pain) and she typically liked to wait "for her pain pill to kick in," before her dressing change was completed. R118 asked LPN-F to return in a half hour to complete her dressing change and to bring an ice pack. At 10:01 a.m., R118 stated, "[Her pain medication] never quite cuts it... when they start scraping, there's nothing [that could stop the pain]." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m. LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she

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2 830	Continued From page 41 held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, it's starting to burn." LPN-F asked R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated, "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118. During interview on 10/22/15, at 10:51 a.m. LPN-F confirmed the verbal and non-verbal pain indicators she observed, which was a typical reaction during her dressing changes. LPN-F reported R118's doctor and nurse practitioner were aware of these symptoms. LPN-F stated	2 830		

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2 830	Continued From page 42 R118's pain management regimen consisted of offering Ultram first, then oxycodone if the Ultram was not effective. LPN-F added, she could also have ice at any time and this has been the same pain management regimen for R118 for some time. She was not sure what the rational of the physician was, for not making further changes to the pain medicaiton regimen. LPN-F stated, She trys to give her (R118) time when she removed the dressing, so she (R118) can take a breath and "get her bearings" and will then continue when she is ready. R118's current physician orders dated 10/26/15, directed the following wound treatment and pain management regimen: ·Wound treatment to stasis ulceration on right lower extremity- cleanse wound, apply Silversorb, cover with ABD pad and Kerlix, change dressing daily and PRN. ·Gabapentin 300 milligrams (mg), twice daily for peripheral neuropathy/ polyneuropathy. ·Ultram 50 mg, every four hours PRN for pain, for chronic pain syndrome. ·Oxycodone 5 mg, every four hours PRN for pain not relieved by Ultram, for chronic pain syndrome. Review of R118's physician progress notes from 8/17/15, to 10/26/15, identified the following: R118's New Patient History and Physical Examination, completed by medical doctor (MD)-A and dated 9/3/15, noted she had osteoarthritis affecting her knees, shoulder and hip, with residual pain post knee and hip arthroplasties. The report did not further address her pain. On 8/24/15, nurse practitioner (NP)-A noted R118 had complaints of pain to her right lower extremity with dressing changes. On 9/10/15, NP-A noted the appearance of	2 830		

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2 830	Continued From page 43 R118's right lower leg and reviewed the dressing treatments. NP-A noted, "Discussed pain control will add oxycodone for mod [moderate]/severe pain." On 9/23/15, a Wound Care/ Hyperbaric Medicine History and Physical noted, "There is a wound on the anteromedial portion of [R118's] right lower leg. This measures 11 x [by] 12.5 x 0.1 cm [centimeters]. The wound is about 60% yellow fibrin and 40% pale red. It is very tender to touch and I am unable to do any sort of debridment on it. It does not appear to be infected... I initially tried to dress the patient's wound with Medihoney; however, the patient developed a lot of discomfort with this. My initial inclination had been to treat it with Iodosorb in an attempt to control drainage but the patient was afraid that that would be painful... She did receive a dose of oxycodone here and once her pain got better her wound was then dressed..." On 10/8/15, NP-A addressed R118's chronic right lower leg ulcer. NP-A noted, "Resident today says, 'I'm ok,' but frowning and awaiting R [right] LE [lower extremity] dressing [change]. C/o [Complains of] pain to R LE. Refuses to go back to Monticello Wound Clinic- 'They don't know nothing.' She is very particular about what she will allow to be put on R LE wound... looks unhappy- waiting for dressing [change]." The note directed no change to the wound treatment and to continue with antibiotic treatment for cellulitis through 10/12/15. On 10/19/15, NP-A noted R118's emergency room visit was reviewed. The note did not address R118's stasis ulcer. No further assessment, description, or plan for pain management were included in the physician progress notes. Review of R118's Electronic Medication	2 830		

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2 830	Continued From page 44 Administration Record (EMAR) from 9/1/15, to 10/25/15, identified the following as PRN pain medications were administered for right, lower extremity and leg pain. The September 2015 EMAR identified R118 took a total of 103 doses of PRN pain medication. She took 68 doses of Ultram 50mg, which were effective 42 of 68 opportunities; slightly effective 14 of 68; not effective 2 of 68, and other, which was not identified for 1 of 68 opportunities. R118 had 35 doses of PRN oxycodone 5mg in September 2015, which was effective 14 out of 35 opportunities; slightly effective 3 out of 35; and other which was not identified 3 out of 35, opportunities. The October 2015 EMAR identified R118 was administered 100 doses of pain medication for right, lower extremity leg pain. She took 49 doses of Ultram 50mg, which was effective 18 out of 49 opportunities; slightly effective 17 out of 49; and not effective 6 out of 49 opportunities. R118 had 51 doses of PRN oxycodone 5mg, in October 2015 which was effective 34 out of 51 opportunities; slightly effective 11 out of 51; not effective 5 out of 51 and other, which was not identified, 1 out of 51 opportunities. Review of the EMAR PRN administration times from September to October 2015, did not correlate with R118's dressing changes, because the dressing changes were not consistently documented. Even though R118 was administered 203 doses of PRN pain medication, taken in 55 days, approximately 3.7 doses of PRN pain medication	2 830		

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2 830	Continued From page 45 each day, along with her scheduled Gabapentin 300 mg twice a day. R118 continued to experience significant pain with her dressing changes. Review of R118's nursing progress notes from 8/17/15, through 10/26/15, identified complaints of pain for R118: On 8/24/15, at 10:18 p.m. LPN-G noted, "Changed dressing on lower right leg ... About an hour later Resident had c/o a 'burning pain.' Writer asked if a pain pill would help or if it was too much and it needed to be taken off? Resident asked for it to be taken off. Writer took off dressing... cleaned wound and only applied Bacitracin with non-stick dressing then covered with ABD and wrapped with Kerlix. Resident has not have any further c/o pain but is requesting that she receive something else on the wound that won't burn." On 8/27/15, at 1:09 a.m. LPN-D noted, "[R118] rates pain 8/10; ...per resident alginate dressing 'burns' refused to have on skin; ...communication being sent to update PMD [primary medical doctor]." On 8/27/15, at 10:23 a.m. LPN-F noted, "Leg dressing changed... Area continues to be red, macerated et [and] tender to the touch... Resident claims the wound spray hurts her when use for washing wound. Resident refused it to be used on her D/T [due to] reported pain." On 9/6/15, at 10:48 p.m. LPN-D noted, "[R118] c/o pain in RLE... dressing removed per [R118's] request; cool cloth applied with some relief; leg has been elevated; will reassess in one hour when may have prn pain medication." On 9/7/15, at 1:39 p.m. registered nurse (RN)-C noted, "[R118] refused to have dressing put on in fear that it would start hurting again... [R118] is leaving it open to air. PRN given."	2 830		

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2 830	Continued From page 46 On 9/8/15, 2:28 p.m. LPN-B noted, "Writer called the on call MD/NP and left a message regarding resident's wound on her leg. Resident is refusing to let staff place a dressing on her leg per orders." On 9/8/15, 11:10 p.m. LPN-C noted, "[R118] c/o pain to RLE. [R118] is unable to have any more prn pain medication for another 2 [two] hours. On call physician... said to use standing order of Tylenol. Will administer Tylenol and continue to monitor." On 9/13/15, at 12:25 p.m. LPN-B noted, "... [R118] does c/o pain during a.m. dressing change... PRN pain medication given x [times] 2 at this time." On 9/19/15, at 1:12 a.m. LPN- D noted, "[R118] c/o 7/10 pain right lower extremity; somewhat relieved with prn Tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]." On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, 'It burns so bad when drainage is left on my leg.'" On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds were given closer together. Resident has been seen by NP. Area on leg measures 16 cm x 10 cm draining et macerated with some greenish color at first change when NP was in room." On 10/12/15, 2:27 p.m. LPN-F noted, "[R118] continues to c/o pain. PRN pain meds given x 2. Resident makes requests for dressing changes. Leg continues to be painful et macerated during dressing changes." On 10/15/15, at 12:09 p.m. LPN-J noted, "Treatment completed to RLE... C/o pain while treatment is being completed, had received pain med prior to tx [treatment] being done. States that it hurts when it is open to air."	2 830		

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2 830	Continued From page 47 On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication." During interview on 10/26/15, at 10:42 a.m. nursing assistant (NA)-A stated, R118 has pain in her legs and she had seen her "pretty upset and crying." NA-A stated has seen R118 in pain and/or has complained of pain to her almost daily. NA-A stated she told the facility nurses when R118 complained of and/or appeared in pain, to see if she could be given any pain medication. NA-A stated the pain medications seemed "somewhat effective, [but] never 100% [effective]." During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's pain was mainly in her right lower leg, where she had an open area. RN-H stated the area has been improving, but was taking a long time. Upon review of the EMAR, RN-H reported R118's pain rating was typically around an 8 (0-10 pain scale) prior to receipt of her PRN pain medications. She reported R118's physician was at the facility every Thursday and was responsible for monitoring to ensure her pain management regimen was sufficiently effective. RN-H stated the most recent notation of the physician/ nurse practitioner commenting on her pain was the physician's progress notes, on 10/8/15. RN-H reported R118 had attended a wound clinic, but stopped going after 9/23/15, because she was very upset and did not want to go there anymore. RN-H stated she had spoken to R118 about her pain, as recently as 10/14/15, and she had indicated satisfaction with her pain management regimen. Upon inquiry as to R118's acceptable level of pain, RN-H replied she was unsure. RN-H stated that she was aware R118 had significant pain with	2 830		

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2 830	Continued From page 48 dressing changes, but believed the current pain management regimen was effective for her. She stated the nature of R118's wound was going to result in some, inevitable pain during dressing changes. However, when told of the observed dressing change on 10/22/15, RN-H denied knowledge of R118 having reactions to that extreme. RN-H stated, "If she [R118] is saying she is having that much pain, she is having that much pain." RN-H denied any reports of pain concerns for R118, from the facility nurses or NAs. RN-H stated, she expected staff would have updated the physician if/when they identified unmanaged pain, as the physician could have looked at getting an increase in R118's pain medication. RN-H stated R118's use of the ice pack was typical, however, "If that was what we were seeing, then that would not be a sufficient management of her pain." RN-H confirmed, R118's pain should have been reassessed. RN-H confirmed the facility used section J of the MDS as their sole pain assessment, which was only completed on a quarterly basis. During interview on 10/26/15, at 5:11 p.m. the director of nursing (DON) stated she gas completed R118's dressing changes on a frequent basis. She made sure R118 was medicated about one hour before the dressing change and asked her (R118) frequently throughout the dressing change, how she was doing. The DON stated she soaked the Silversorb in a significant amount of normal saline to keep it from sticking to her leg and made sure she had an ice pack to use for her leg at the time of dressing change. The DON stated she typically looked at R118 and tried to get her to laugh, distracting her during the dressing change. The DON stated she felt these interventions were "as effective as they can be." The DON stated, when	2 830		

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2 830	Continued From page 49 R118 was first admitted to the facility, the dressing changes were much more painful than they were presently. The DON stated she had never seen R118 cry during a dressing change and upon discussion of the observed dressing change (10/22/2015), she denied having seen that kind of response from R118 any time she had completed or observed her dressing changes. The DON stated she expected some discomfort with this type of dressing change, but if R118 had demonstrated significant signs of pain as identified in the 10/22/15 observation, she expected the nurses to document this in the medical record and see what they could do about getting some different analgesic medications for her. Although R118, had a stasis ulcer, had frequent progress notes that identified significant pain, and had nurses and nursing assistants who observed R118 in pain, either during her dressing changes or other times during the day. R118 only received Gabapentin 300 mg twice a day, for a routine scheduled pain medication, and Ultram 50 mg PRN for pain and oxycodone 5 mg PRN for moderate to severe pain. R118 only received the Gabapentin 300 mg prior to her dressing change in the morning of 10/22/2015, and then received oxycodone 5mg after the dressing change was completed. Even though R118 voiced complaints of unmanaged pain, and demonstrated distressing pain during a wound dressing change. The facility did not comprehensively assess and developed an appropriate pain management interventions to assist in reducing her pain. This resulted in actual harm for R118. The facility's Dressing Change, Clean policy dated 6/14, directed nursing to check physician orders to see if a resident required an analgesic	2 830		

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2 830	Continued From page 50 prior to completion of dressing changes and to administer any analgesic medication as ordered. The policy did not further address pain management during dressing changes. Facility policies regarding pain management with dressing changes were requested, but no additional policies were provided. WHEEL CHAIR POSITIONING R57's quarterly MDS dated 9/22/15, identified R57 used a wheelchair for mobility, and required extensive assistance with activities of daily living (ADLs). R57's care area assessment dated 4/21/15, indicated she had contractures, and limited range of motion. R57's care plan dated 9/23/15, indicated alterations in mobility related to increasing weakness and directed staff to refer to physical and occupational therapy as needed. A Resident Progress Noted dated 9/13/15, indicated "pillow given to resident on wheel chair due to resident leaning to right." A Resident Progress Note dated 9/5/15, indicated R57 was up in wheel chair and would "drift off, leaning to right." During and observation on 10/19/15, at 8:16 p.m., R57 was sitting in a wheel chair. She appeared to be sleeping with her head resting on her right arm, leaning to her right. On 10/20/15 at 9:58 a.m., R57 was again observed sitting in her wheel chair, leaning to her right side. On 10/21/15, at 8:58 a.m., R57 was leaning to her right side in her wheel chair with her head resting on her tray table. On 10/23/15, at 3:55 p.m., R57 was observed sitting in her wheel chair, leaning to her right side with her head resting on a pillow that was placed on the right arm rest of her wheel	2 830		

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2 830	Continued From page 51 chair. Although R57 continued to lean to the right, there were no supports noted in her wheelchair to support her trunk that prevented her from leaning. During and interview on 10/23/15, at 11:32 a.m., NA-B stated R57 refuses to lay down a lot of the time, that's why we put pillow by her head. NA-B further stated R57 "has always leaned to the right side, not sure why that is." During an interview on 10/23/15, at 11:48 a.m., occupational therapy assistant (OTA)-J stated R57 was recently given a right lateral support for her wheel chair. OTA-J stated R57 was seen for a referral "about a month or so ago," but was not picked up for ongoing therapy. He felt R57's chair size was appropriate but that (R57) was more fatigued. During an interview on 10/26/15, at 1:53 p.m., NA-T stated, R57 is like that "all the time," they get her up for breakfast and then she falls asleep in her wheel chair. NA-T further stated, she used to lean a little but her leaning has been going on for the past few weeks. During an interview on 10/26/15, at 2:07 p.m., LPN-H stated, some they they have difficulty getting her (R57) to lay down. Sometimes they will place a pillow under her head to buffer the uncomfortable position but, "she always looks like that." LPN-H further stated, she though this was her second chair, and was unsure if (R57) had lateral supports or if they helped or not. R57 was at high risk for falling out of her chair because she is always leaning to her right. LPN-H further stated, R57 had been screened by occupational therapy for positioning, but was unsure if she had been re-evaluated.	2 830		

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2 830	Continued From page 52 During an interview on 10/26/15, at 2:32 p.m., occupational therapist (OT)-K and OTA-J stated, they had received a referral in September for R57 because of her leaning and gave her a lateral supports. They also recommended she (R57) lie down if tired and listed the potential for several negative outcomes of a sore back, and neck. At the time of the referral in September 2015, the lateral support was providing R57 with the amount of assistance she needed to sit up right and be able to propel herself in her wheel chair. OT-K and OTA-J further stated, R57 was "never leaning that bad when we saw her" and that her current positioning was a change and she should have been referred back to therapy for an evaluation. A policy addressing positioning for residents was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to pain management, proper positioning and coordination of care with outside providers. Responsible personnel could be re-educated on these policies and procedures. The individual(s) identified in the deficiency could be reassessed for the needs identified, with supporting documentation maintained. Other residents could be evaluated for appropriate pain management, proper positioning and coordination of care with outside service providers. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		

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2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct	2 840		12/29/15

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2 840	Continued From page 54 contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bathing was completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. Findings include: LACK OF BATHING: R45's annual MDS dated 8/11/15, identified R45 had intact cognition, and required physical assistance from staff to complete her bathing. During interview on 10/22/15, at 1:46 p.m. R45 stated she does not always receive her schedule bath because of the facility being short staffed. Further, R45 stated not receiving her bath consistently makes her "angry", and she would like to have her bathing completed. Facility Lakeside Oasis Bath Records dated 9/14/15 to 10/21/15 were reviewed. The records were constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. R45's name was identified on the records, however for three weeks there were no	2 840	Corrected.	

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2 840	Continued From page 55 staff initials identified next to her name to identify she received bathing. The spaces provided to record initials were left blank. When interviewed on 10/22/15, at 1:36 p.m. NA-C stated R45 enjoyed her showers, but added they were sometimes not completed due to a lack of staff to complete them. During interview on 10/23/15, at 11:59 a.m. RN-A stated she was not aware R45 was not receiving her baths as scheduled, but added it "wouldn't surprise me." Further, RN-A stated R45 should have been given her baths as scheduled. R19's quarterly MDS dated 9/29/15, identified R19 had intact cognition, and required assistance from at least two staff to complete her bathing. During interview on 10/22/15, at 2:11 p.m. R19 stated she was supposed to receive a bath twice a week, but had to go without her baths at times because there was "not hear enough" staff at the facility. Further, R19 stated she wanted to receive all of her scheduled baths as it was "very" important to her. A facility Mill Creek Bridge Weekly Bath and Vital List dated 8/3/15 to 10/21/15, identified R19 was scheduled for a bath twice a week. The listing was constructed by identifying the days of the week, and staff were to identify a resident on which day they received their bath by writing their name on the form and initialing next to it when completed. However, R19 was not provided her baths for four of sixteen scheduled times according to the record. When interviewed on 10/22/15, at 1:36 p.m.	2 840		

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	00714	A. BUILDING: _____ B. WING _____	10/26/2015

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2 840	Continued From page 56 NA-C stated R19 enjoys her baths, but added some have been missed because there were no staff available to complete it. During interview on 10/23/15, at 11:59 a.m. RN-A stated her expectation was for staff to complete bathing as required for residents. A facility policy on bathing was requested, but none was provided. LACK OF TIMELY PERICARE: R126's admission Minimum Data Set (MDS) dated 9/25/15, identified R126 had intact cognition, required extensive assistance for toileting and personal hygiene, and was continent of bowel. R126's care plan dated 10/12/15, identified R126 had an alteration in his elimination related to decreased mobility, but remained continent of bowel. Further, the care plan directed staff to complete, "Pericare with assist of 1 with am [morning] and HS [hour of sleep] cares." The care plan did not identify if or when pericare should be completed for toileting not associated with those set times. During interview on 10/20/15, at 3:22 p.m. R126 stated he was dependent on staff for help with pericare after having a bowel movement, however he did not always receive timely assistance with this. R126 used a bed pan, but stated his bottom would get sore if he sat on it for too long, so he would remove himself from the bed pan, and place newspaper underneath of himself to prevent the bed linens from becoming soiled while he waited for staff assistance with pericare's.	2 840		

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2 840	Continued From page 57 When interviewed on 10/26/15, at 10:27 a.m. nursing assistant (NA)-A stated she had assisted R126 with toileting and pericare's before, and noticed feces soiled newspaper on his bed before. NA-A stated she was unaware R126 was using it as a barrier to prevent the linens from becoming soiled while waiting for staff assistance. During interview on 10/26/15, at 2:18 p.m. registered nurse (RN)-H stated she was unaware R126 was using the newspaper after having a bowel movement while he waited for assistance with pericare's. A letter submitted post survey exit dated 10/28/15, authored by NA-T noted, "A couple of times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put himself on bedpan, notifying staff only when he was done." A letter submitted post survey exit, dated 10/30/15, authored by NA-D noted, "[R126] chose to use newspaper under himself even though I told him he didn't need to do that and we would change linen if it got soiled. He continued to put newspapers under him." A facility policy on toileting and pericare was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to the provision of assistance with activities of daily living (ADLs). Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of ADL	2 840		

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2 840	Continued From page 58 services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate provision of ADL services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 840		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), who needed staff assistance with activities of daily living (ADLs. R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete her personal hygiene. During observation on 10/20/15, at 9:16 a.m. R5 was seated in a recliner chair in his room. R5	2 860	Corrected.	12/29/15

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2 860	Continued From page 59 had visibly long fingernails on both hands with a dark colored substance underneath several of the nails. R5 stated he was diabetic so "not everybody can cut them", but added his preference would be to have shorter nails. On 10/22/15, at 9:01 a.m. R5 continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. nursing assistant (NA)-T stated R5 seldom refused cares or assistance from staff, and nail care was to be completed on residents scheduled bath days. At 2:03 p.m. NA-T observed R5's nails and stated they were too long, and "not very clean underneath." Further, NA-T stated they were unaware of any preference of R5 to have long, dirty fingernails and they should be trimmed. During interview on 10/22/15, at 2:33 p.m. licensed practical nurse (LPN)-A observed R5's long, dirty fingernails and stated "they need to be cut." Further, LPN-A stated R5 was dependent on nursing staff for his nail care, and his nails should have been trimmed and cleaned on his bath day. When interviewed on 10/23/15, at 11:23 a.m. registered nurse (RN)-A stated R5 required assistance to complete his nail care, and his nails should have been cleaned and trimmed, "[They] should be taken care of when they get their bath done." R64's quarterly MDS dated 9/15/15, identified R64 had moderate cognitive impairment, and required extensive assistance from staff to complete his personal hygiene. During observation on 10/20/15, at 9:36 a.m. R64	2 860		

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2 860	Continued From page 60 was seated in a standard wheelchair in his room. R64 had visibly long fingernails with several nails having a dark colored substance underneath several nails. R64 stated he preferred to have shorter kept nails adding they "could use a clip." On 10/22/15, at 9:04 a.m. R64 was seated in his wheelchair outside his room, and continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. NA-T stated R64 had never refused cares or staff assistance to their knowledge. At 2:03 p.m. NA-T observed R64's nails and stated they were "very long" and should be cleaned and trimmed. During interview on 10/22/15, at 2:33 p.m. LPN-A observed R64's nails and stated they should have been cleaned and trimmed on his bath day. When interview on 10/23/15, at 11:23 a.m. RN-A stated R64 had no desired preference to have long, dirty fingernails and they should have been cleaned and trimmed on his bath day. A facility policy on grooming and nail care was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to the provision of nail care. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of nail care services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate nail care. An auditing system could be developed and implemented, with results shared with the facility's	2 860		

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2 860	Continued From page 61 Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 860		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote urinary continence for 1 of 3 residents (R64) reviewed for urinary incontinence. Findings include: R64's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R64 had moderate cognitive	2 910	Corrected.	12/29/15

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2 910	Continued From page 62 impairment, required extensive assistance with toileting and was, "Always incontinent" of bladder. R64's Nursing Observations 3.0 Assessment dated 9/18/15, identified R64 to be "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." The assessment did not identify if any or what type of a toileting program needed to be implemented for R64, to decrease R64's incontinence. R64's care plan dated 9/21/15, identified R64 had an, "Alteration in elimination r/t [related to] weakness following hospitalization", but R64 was, "Aware of the need to void/defecate." Further, the care plan directed staff to, "Toilet per request", and, "Monitor for changes in elimination patterns and reassess quarterly and prn [per request or as needed]." During interview on 10/22/15, at 9:43 a.m. nursing assistant (NA)-T stated he helps R64 to the bathroom when he requests as care planned, but has noticed R64 to be "more incontinent of urine" lately. Further, NA-T was unaware of any set toileting schedule for R64. During observation of care on 10/23/15, at 7:24 a.m. R64 was assisted to the toilet by NA-F. NA-F removed a visibly soiled white incontinence pad from R64, and placed it in the trash stating R64, "Had the wrong kind of pad on." R64 should have had an "extra absorbent" green colored pad on during the night to help reduce irritation to his skin from being incontinent. NA-F stated R64's removed incontinence pad "was full" of urine, as R64 was typically incontinent in the morning, but when assisted to the toilet would sometimes void. Further, NA-F stated R64 was unable to verbalize	2 910		

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2 910	Continued From page 63 when he needed to use the restroom, so she helped him "every two hours" to the restroom. During interview on 10/23/15, at 11:34 a.m. registered nurse (RN)-A stated R64 was able to voice his need to use the restroom, "Most of the time", and should be helped with toileting every two hours. R64 should not be incontinence of urine, "More than a couple times a day," with his toileting ability, and the assessment completed on 9/18/15 should have identified a toileting program for R64 to promote continence. Although R64's assessment identified him as "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." There was no indication if R64 needed a scheduled toileting program, or was a check and change (no attempts to place on the toilet) even though R64 had been using the toilet, and NA-F stated he did have some continent voids. A facility policy on urinary incontinence was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who are incontinent of bladder to assure they are receiving the necessary treatment/services to assist with continence status. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for bladder incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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21330	Continued From page 64	21330		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon in a timely manner for 1 for 3 residents (R85) reviewed for dental hygiene and who needed new dentures. Findings include: R85's quarterly Minimum Data Set (MDS) dated 9/1/15, identified R85 had intact cognition. During observation on 10/20/15, at 10:10 a.m. R85 was seated in his room in a wheelchair. R85 had visible missing teeth on his lower palate, and his upper denture moved in his mouth while he	21330	Corrected.	12/29/15

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21330	Continued From page 65 spoke. R85 stated his dentures were getting, "Worn down", and were, "Not effective anymore." R85 stated at times he had trouble chewing food because of the loose fitting dentures, and would like to have them looked at by a dentist. R85's Patient Progress Notes dated 8/11/15, identified R85 had been seen by the dentist who visits the facility. The dentist identified, "Pt [patient] has full upper and lower partial. Lower partial denture is not anchored on any teeth as all remaining lower teeth are fractured off at the gumline ... Both full upper and lower partial have extreme occlusial wear, and pt it using adhesive on both for retention. Pt is interested in new upper only ..." The dentist identified a treatment plan of, "Will tx [treat] plan full upper and full lower dentures and if pt decides to proceed, we can refer to an oral surgeon for the extractions of remaining lower teeth [roots]." R85's facility progress notes dated 8/11/15, identified R85, "...was seen by In House Dental ... recommends that resident has all remaining lower roots extracted with an oral surgeon & [and] then have a new full upper and lower denture made ... will discuss these recommendations with resident and if he chooses will send him out to a consult to pursue..." No further notes were identified in R85's medical record as having the follow up completed for new dentures as requested by R85 and the dentist. During interview on 10/26/15, at 10:05 a.m. registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85.	21330		

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21330	Continued From page 66 During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to dental services. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of dental services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate provision of dental services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21330		

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21375	Continued From page 67	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement infection control practices and procedures to prevent the spread of infection for 1 of 3 residents (R118) observed during a wound dressing change. Findings include: R118's undated Resident Admission Record identified diagnoses including cellulitis of the right lower extremity, non-pressure chronic ulcer of lower right leg with unspecified severity-non-healing, and pseudomonas in wound. R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was intact and required limited assistance for most activities of daily living (ADLs). On 10/22/15, at 10:16 a.m. licensed practical nurse (LPN)-F was observed completing a dressing change to R118's open wound to the right lower leg. LPN-F gathered the necessary supplies, laid a clean towel directly on the floor beneath R118's right foot, while R118 remained seated in her wheelchair. No barrier was placed between the towel and the floor. After washing her hands and applying gloves, LPN-F removed	21375	Corrected.	12/29/15

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21375	Continued From page 68	21375		

the soiled stockinet (a stretchy fabric used for bandaging), removed the soiled dressing with use of a small scissors, and then removed the absorption pad over the open wound to R118's right lower leg. The dressing and absorption pad were discarded in the trash, but the stockinet and scissors were set aside, while LPN-F proceeded to use Simply Saline Wound Wash to soak and loosen a Silversorb (antimicrobial wound dressing) from R118's open wound. Dark brown debris and slough was observed to break free from the wound and drip onto the towel beneath R118's foot. LPN-F removed the dark brown debris away from the wound using the saline wash to break it up and removed it. The saline wash, mixed with debris/ slough, was dripping from R118's right lower leg, onto the towel. The towel was visibly soaked through, in a circular area beneath R118's right heel, approximately six inches in diameter. At 10:27 a.m., LPN-F removed her gloves and washed her hands after cleansing the wound. At 10:29 a.m., LPN-F applied new dressings and a clean stockinet to the wound, then placed R118's foot back onto the footrest of her wheelchair. LPN-F folded the towel inward and draped it over the lined garbage bin. She picked up her supplies and stepped back behind R118, next to the night stand. LPN-F rested the scissors atop a Dycem mat, which covered the top of R118's night stand. No barrier was placed between the scissors and the Dycem mat. She then reached to open one of the night stand drawers. At this time, R118 self-propelled her wheelchair forward approximately 18 inches, so LPN-F could open the drawers and put away her supplies. The right front and back wheels of R118's wheelchair was observed to roll over the area of the floor that became soiled by the soaked towel. Once LPN-F had finished accessing the night stand drawers, R118

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self-propelled her wheelchair back through the same area and returned to her original position. At 10:37 a.m., LPN-F retrieved a Clorox disinfectant wipe from her medication/treatment cart and wiped the flooring beneath where the towel was placed, then obtained another sanitizing wipe from her cart and returned to wipe the scissors clean and return it to one of the night stand drawers. LPN-F did not wipe the Dycem mat where she had rested the soiled scissors on R118's night stand. LPN-F stepped away from the area and the original (soiled) stockinet which had been set aside earlier, was draped over a thin metal bar of R118's wheelchair, located behind the right foot rest, near the right front wheel. The stockinet was observed with multiple, circular, light to dark brown spots of dried wound drainage.

During interview on 10/22/15, at 10:51 a.m. LPN-F stated it was her typical practice to use a towel directly on the floor to, "Sop up any fluids that drip to the floor," during R118's wound dressing changes. LPN-F stated she used a Clorox disinfectant wipe to clean the surface of the floor after the dressing change. LPN-F stated she did not realize R118 propelled her wheelchair through the soiled area of the floor before she disinfected it. LPN-F stated when she was cleaning up the supplies R118 removed the stockinet from the soiled linens she had gathered, and it was R118's preference to rinse out her stockinet and re-use them, rather than send them through the laundry. When LPN-F was asked about placing the soiled scissors on top of the Dycem mat on R118's night stand, she stated, "[I] had to put it somewhere..." LPN-F stated she typically tried to keep the scissors apart from her clean dressings and to keep it off of the floor, and LPN-F stated she thought she had wiped the area

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21375	Continued From page 70 where she had set the scissors with a sanitizing wipe. During interview on 10/26/15, at 2:24 p.m. registered nurse (RN)-B, the facility's infection control coordinator, stated disinfectant and sanitizing wipes should have been amongst the supplies LPN-F gathered for R118's dressing change. RN-B stated without a proper barrier beneath the towel, LPN-F should have disinfected the flooring immediately, and if the wheelchair did come in contact with the soiled area, it should have been sanitized immediately. RN-B also stated a barrier should have been placed between the soiled scissors and R118's night stand, and the soiled stockinet should have been sent to the laundry and replaced with a clean one. RN-B stated if the material was obviously soiled it needed to go to the laundry for cleaning. The facility's Infection Control Committee- Duties and Responsibilities policy dated 6/14, directed the facility's committee was responsible for developing training programs for all facility personnel on infection control policies and procedures. The committee was also responsible for ensuring the facility maintained a sanitary environment, with all personnel following established infection control procedures and precautions. The facility's training program was to include the use of protective barrier equipment, along with the decontamination and disposal of equipment when exposed to blood/ bodily fluids. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to infection control practices during dressing changes. Responsible personnel could be re-educated on these policies and procedures.	21375		

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21375	Continued From page 71 An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure employees received a two-step tuberculin skin test (TST) for 5 of 8 new	21426	Corrected.	12/29/15

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employees whose personnel records were reviewed. This had the potential to affect all 42 residents who resided in the facility.

Findings include:

Review of personnel files for a sample of new employees, identified nursing assistant (NA)-B was hired on 7/23/15. Although an initial TST was administered on 7/23/15, and read as negative with no induration on 7/25/15, a second step was not completed.

Maintenance-A was hired on 8/26/15. Although an initial TST had been administered on 8/26/15, and read as negative with no induration on 8/28/15, no second step had been completed.

NA-E was hired 9/10/15. Although an initial TST had been administered on 9/10/15 and read as negative with no induration on 9/13/15, no second step had been completed on entrance of the survey team.

Dietary aide (DA)-A was hired on 9/10/15. Although and initial TST had been administered on 9/10/15, and read as negative with no induration on 9/12/15, no second step had been completed.

Licensed practical nurse (LPN)-E was hired on 10/14/15. Although the first step TST had been administered on 10/14/15, the TST had not been read as of 10/22/15.

During interview on 10/26/15, at 5:32 p.m. registered nurse (RN)-B stated she did the TSTs on the new employees and the second step was to be completed two to three weeks after the first step.

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21426	Continued From page 73 The facility's Regulation for Tuberculosis Control in Minnesota Health Care Settings policy dated 7/13, directed testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single interferon gamma release assay (IGRA). SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to the required tuberculosis skin testing process. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medically related social services needs were identified and provided for 3 of 4 residents (R29, R28 and R56) reviewed for social services. This resulted in	21475	Corrected.	12/29/15

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21475	Continued From page 74 actual, psychosocial harm for R28, who expressed fear, inability to sleep, and demonstrated signs of distress regarding concerns with her roommate (R29). Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/25/15, indicated the resident had severe cognitive impairment and had dementia with depression. R28's quarterly MDS dated 9/1/15, indicated the resident had severe cognitive impairment, and had dementia with depression. The MDS indicated R28 was depressed, had trouble sleeping, had little or no energy, felt bad about herself, and had trouble concentrating. R28's Care Area Assessment (CAA) dated 6/12/15, indicated the resident received Zoloft, an antidepressant, for diagnosis of depression. R28's care plan dated 9/11/15, indicated she was depressed and was to receive one to one visits to encourage expression of feelings and to, "Explore possible reasons for the resident's distress (e.g., environmental/psychosocial stressors, treatable medical conditions, etc); Implement a mood management plan to compliment drug therapy : sertraline (Zoloft)." The care plan indicated R28 had the potential for abuse from others related to cognitive loss, and the approach was for staff to discuss behavioral issues with the team members as needed, and evaluate the need for psychological referral and evaluation. R28's progress notes reviewed from 7/09/15, to 10/25/15, indicated the following incidents related to R29, who is R28's roommate:	21475		

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21475	Continued From page 75 On 7/9/15, "Res. [resident] has been crying today. Res. is stating how when she was little her mom used to make her watch the baby and she didn't like it. Res. has also been say that her roommate asks so many questions and needs things and she is getting tired." On 7/15/15, a note documented by activities indicated "Resident is having a hard time with her rooming situation. She says she is not getting much sleep because roommate is up a lot at night talking, delusional as to where she is and accusing resident of things. Resident is crying a lot and is in hopes of changing rooms. Writer consoled resident and said she would see what she could do about the situation." On 8/24/15, resident and roommate had a dispute. R28 stated her roommate yelled at her and she became upset, was crying, and stated she was done dealing with her roommate and wanted a new room. On 8/25/15, a progress note from social services indicated, "Spoke with res regarding incident with roommate last night, res did remember arguing with her roommate. She didn't say she wanted a different room today, but just said that she didn't want to talk to her roommate about just anything, only the weather. Writer validated her feelings letting resident know she doesn't have to talk to roommate about anything she didn't want to." On 9/1/15, "Resident refusing to go into bed as roommate blocking roommate from entering. Resident when in room, 'peeks' into roommates side of room to make sure she is okay." On 9/5/15, resident talked with writer and stated,	21475		

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21475	Continued From page 76 "I'm loosing my mind, my roommate is rubbing off on me; up at 1 am. Talks of wanting a different room, did leave a message for SW [social worker], 1 on 1 with resident, and was effective at this time." On 9/10/15, resident complaints of not sleeping well last night stating the lady in her room kept her up asking who she is and where she is. On 9/10/15, progress note from social services indicated, "Writer was walking down the hall and res stopped writer and was upset because she stated 'I just saw on TV that I am being taken to court! I have nothing, this is not fair they stole all my money!' When writer asked who stole her money she was not able to say. Res roommate was then coming out of the room and res said 'oh that little bitch! She was screwing with him all night!' Writer let res know that was not nice to call some one names. Writer asked who him was and roommate got closer res said 'oh look here she is she just wants to screw' and she shook her fist at roommate. Writer directed ladies in opposite direction but it took some time for residents to go there separate ways. Res kept stating that 'this is my room' and 'she goes in there all the time and screws him, she is such a little bitch, I cant even eat- I don't even want to look at her." On 9/12/15, resident found in roommates bed and she stated she does this to me all the time. On 9/23/15, resident stated she was up all night with the lady in her room yelling all night. Resident stated she was, "Going crazy." One to one was given. On 9/23/15, "Writer unplugged cord from computer res. stating 'I wish I had one of those'	21475		

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res was asked what? 'That cord for around my neck- I don't sleep cause of that lady in my room.' Res. stated 'I really wont do that but I never get any sleep with her in there.' 1 on 1 was given with relief. SS updated."

On 10/6/15, social service note indicated residents daughter called, "To talk to writer about concerns that resident called her about a man who was after her and her roommate, who was sleeping with all sorts of men and how resident just wanted to commit suicide. Assured Dtr [daughter] that no men were in the building and that res has talked about seeing the men before and they turn out to be not here and roommate does not have men in her bed at night to which [daughter] stated she figured and was not worried about it. She [daughter] was most worried about the suicide comment. [Daughter] is requesting a call from the MD [medical doctor] when he is here on Thursday and Writer let [daughter] know that she would talk to MD as well about res behaviors. Writer then spoke to res about suicidal behaviors and res has no plans to harm herself and is safe at facility. No further action needs to take place today."

On 10/07/15, "Res in confrontation with another Res in hallway this evening. Res was talking about going to 'See my lawyer this week to see what the weather is going to be.' She was also talking about how another res 'needs her ass kicked.' Res eventually calmed down and went into her room. Will continue to monitor."

A Lake Ridge Care Center Fax Update/Order form dated 10/8/15, indicated the MD attempted to call R28's daughter but had the wrong phone number and he would call the social worker tomorrow.

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21475	Continued From page 78 On 10/20/15, "Writer informed by NAR (nursing assistant registered) that Res claims roommate said she was going to cut her throat. Res called daughter to inform daughter of situation. Writer asked aides what happened. Aides said roommate didn't want to go in room because Res said she didn't want her there. Then Res made the claim that roommate said she'd cut her throat. Aides said roommate wasn't even around Res to make such a comment. Res and roommate separated at this time. Res on her way back to bed." On 10/22/15, social service note indicated "Met with resident and discussed comments she made on 10/20/15. Res stated that she did not feel her roommate was going to slit her throat, res stated she felt safe and was not afraid of her roommate. She stated her roommate just wants the whole room that's all and she just gets that way sometimes. Asked res twice if she felt safe with her roommate during the conversation and both times res waved her hands at writer and said oh yes its fine." On 10/23/15, social service note indicated resident came to writer upset with roommate because of all of her visitors and that she needed to get out of her room because her roommate gets mad at her and shuts the door on her. Because she was so upset writer asked if she felt like hurting herself and res stated, "No, I don't think so." On 10/23/15, "Resident was up at the front door saying 'I am getting out of here.' Writer told resident, Oh it's raining out. You don't want to go out there. Resident replied, I don't care about the rain. I'm not staying here another night; live with	21475		

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these awful people here, I'm leaving. Resident was resistant at first but then writer got resident to go to the Vineyard. Writer reported this info to social services and nursing. At this time nursing put a Wanderguard on resident."

An Associated Clinic of Psychology visit note dated 8/17/15, indicated R28 had depression, and did not have suicidal ideation. The recommendations were to use validation techniques when she appeared to have concerns, or when she voiced concerns.

A Geriatric Services Of Minnesota physician visit dated 9/10/15, indicated, "The patient [R28] did get a bit weepy today while complaining about conflicts with her roommate. I spoke with various staff and apparently the patient has had problems with at least a couple of other roommates and I think she maybe a candidate for a private room." The plan indicated to facility staff, "I will be happy to support a waiver request for a private room."

There was no indication the physician recommendation regarding R28 receiving a private room was followed up on by the facility.

During interview on 10/26/15, at 1:53 p.m. nursing assistant (NA)-T stated R28 and R29 started to have troubles being roommates a few months ago, because R29 gets, "Crazy" in the late afternoon and night time. R29 becomes more confused, and is up hollering during the night. NA-T stated they have come to work in the early morning and R28 would be awake and out of bed crying stating she is fearful of her roommate because R29 was, "Making her uncomfortable." R28 had expressed she, "Doesn't like being in that room," and continued to be "unsettled" about having to remain in the room

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with R29. R28 had ongoing episodes several times a week of not sleeping well at night because of R29, and NA-T stated these concerns were reported to social worker (SW)-A, but SW-A stated she had spoken to R28's family and they didn't want the resident to change rooms, but rather just wanted the facility to add some pictures and music to try to enhance the physical space of the room for R28. NA-T stated one of R28's daughters had recently visited from out of town, and she had expressed desire for R28 to change rooms because she could, "See how it was," between R28 and R29; however, NA-T stated, "Nothing ever got done," about R28 and R29 rooming together.

During interview 10/26/15, at 4:08 p.m. NA-A stated R28 and R29, "Argue all the time, and [R29] is very forgetful; she cant remember five minutes to the next." She forgets what side of the room she is on and they both dig into each others things and it upsets both of them. "[R28] gets upset and will go on a rant that she has no one in her family; she has said she is better off dead but never told me she had a plan. She is not on any suicide checks. We are told there is not enough charting to separate them and the nurses do the charting. It would be nice if they could be separated."

During interview 10/26/15, at 4:13 p.m. licensed practical nurse (LPN)-A stated, "They [R28 and R29] fight a lot. I have asked for a room change and left messages with the social worker. I'm almost ready to give up; we keep charting and nothing gets done with it and the staff are very frustrated, they don't ask us about room changes and about what would work best, and who would be compatible with who. I suggested for her [R28] to move to room 126 when that was open

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because I felt her and the other roommate would be a good fit and they never moved her. [R28] tells me she wants to move.... [R28] says things that she wants to kill herself." LPN-A then stated, "I don't think things are charted as often as they occur." LPN-A stated R28 and R29 just, "Got into it with each other in the hall."

During interview 10/26/15, at 4:23 p.m. R28 stated, "I have never been treated like this ever in my life." R28 started to cry, and LPN-A (who was present at the time of interview) gave her a Kleenex. R28 stated, "I have asked for a different room, I want a different room, and I have told the gals that work here that!" R28 continued to cry wiping her tears with her Kleenex. R28 then began rubbing her head and stated, "Oh my god I am so tired of this, I have it in the back of my mind to end my life. I am 86 years old, why do I have to put up with this?" R28 stated her roommate (R29), "Is nastier than nasty." At 4:33 p.m., R28 was still crying.

During interview on 10/26/15, at 4:36 p.m. social worker (SW)-A stated everyone at the facility was aware R28 and R29 did not get along. SW-A stated she and the director of nursing (DON) had discussed moving the residents to separate rooms, but felt it would not be a benefit to move either one of them. SW-A stated R28 hallucinates and had made comments about a man being in the room when there hasn't been a man around. SW-A stated she was not aware if R29 was keeping R28 up at night, and stated she had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty

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rooms all have roommates, and the facility felt they would rather wait for a private room to open before moving R28. SW-A stated she had not filled out a waiver for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated R28 had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 8/17/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here."

During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken to her about moving R28 to a different or private room.

During interview 10/26/15, at 6:03 p.m. DON stated a lot of the staff know there, "Is a clash between [R28] and [R29]." The DON stated she was not aware where the social worker was at with the situation between the resident, and the SW made the determination regarding resident room assignments, however, the DON stated, "I am not sure why they haven't moved one of them." DON stated she heard about suicidal comments from R28, but was not aware R28 made a comment about wanting a cord for around her neck, and stated, "If she [R28] said that, she had a plan."

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21475	Continued From page 83 R56's undated Resident Admission Record identified diagnoses including diabetes mellitus, bipolar, anxiety, depression and other specified mental disorders due to known physiological condition. R56's Initial Pre-Admission Screening (PAS) Results based on information submitted on 9/9/15, by the Buffalo Hospital social worker SW-C, identified she had a diagnosis of mild intellectual disabilities. The screening noted, "Based on the information provided for this nursing home stay, it appears this person meets the criteria for DD [developmental disability] and needs to be referred to the lead agency for further evaluation. Please note final determination of the need for referral for further evaluation will be made by Senior LinkAge Line ®." A PASRR level 1 screening dated 9/10/15, completed by R56's Wright County case manager/ SW-D declared R56 did not have a developmental disability or related condition (DD/RC), had never been considered to have DD/RC, had no presenting evidence that might have indicated the presence of DD/RC, and had not been referred for nursing or boarding care facility placement by an agency that served persons with DD/RCs. However, an additional PASRR level 1 screening dated 9/11/15, was maintained as part of R56's medical record. This screening was completed by registered nurse (RN)-F, with no associated agency identified on the forms. This screening declared R56 did have a DD/RC and presenting evidence was present that may have indicated the presence of DD/RC. Though conditions were identified, no referral was made for completion of a PASRR level 2 evaluation. The facility did not pursue clarification of these conflicting	21475		

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21475	Continued From page 84 screenings, to ensure R56 received the appropriate supports. Her admission MDS dated 9/17/15, identified her cognition was intact and required extensive assistance for most activities of daily living (ADLs), but required only supervision and set up for eating. The MDS identified R56 was on a therapeutic diet and received insulin medications The CAA dated 9/17/15 noted,"[R56] is needing assistance with all ADLs following hospitalization for hypoglycemia. Needs encouragement from staff to participate. Discharge plan is uncertain. She maybe looking at moving to a group home or foster home. Husband is having difficulty caring for her." The CAA noted R56 was on a therapeutic diet related to her diagnosis of diabetes. The CAA noted, "Resident tolerates diet well with good intakes and good glucose levels." R56's care plan dated 10/22/15, directed staff to provide her with a diabetic diet of mechanical soft texture. The care plan directed R56 was to receive supervision and set up for eating. The care plan did not further address R56's diet, direct interventions to support R56 in management of her diabetes, direct interventions to support R56 in relation to her intellectual disability, or direct coordination of care between the facility and R56's county case manager. Her physician orders dated 10/23/15, directed the following: GlucaGen 1 milligram (mg); intramuscular injection; one dose as needed for severe low blood glucose when R56 was unable to take sugar by mouth, started on 10/2/15. Lantus 100 units/ milliliter (mL) 30 units; subcutaneously injecting once daily at bedtime,	21475		

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21475	Continued From page 85 for diabetes, with dosing adjusted on 10/23/15. Novolog 100 units/mL 6 units; subcutaneously injecting before breakfast, before lunch and before supper and holding if R56's blood glucose was less than 150, for diabetes, with dosing adjusted on 10/23/15. Novolog Flexpen 100 units/mL sliding scale (200-250 = 3 units, 251-300 = 5 units, 301-350 = 8 units, 351-400 = 10 units, >400 = 12 units); subcutaneously injecting before breakfast, before lunch and before supper, for diabetes, with dosing adjusted on 10/23/15. Accucheck (blood glucose monitoring) at 3:00 a.m., 7:00 a.m., 11:00 a.m., 4:00 p.m. and 7:00 p.m. daily, ordered on 10/23/15. Diabetic diet with mechanical soft textured food, with an order date of 10/2/15. "Very important for patient to be on a diabetic diet. All junk food should be removed from patient's room." The order start date for this directive was 10/14/15. Review of R56's Vitals Report from 9/10/15, through 10/26/15, identified her blood glucose levels were unstable, with extreme highs and extreme lows. Blood glucose readings under 50 mg/ deciliter (dL) and over 500 mg/dL included the following: 9/12/15 (45 mg/dL), 9/15/15 (44 mg/dL), 9/16/15 (45 mg/dL), 9/24/15 (44 mg/dL), 9/27/15 (572 mg/dL), 10/2/15 (586 mg/dL), 10/7/15 (554 mg/dL), 10/8/15 (539 mg/dL), 10/20/15 (48 mg/dL), and 10/23/15 (24 mg/dL), and 10/25/15 (532 mg/dL). Review of progress notes from 9/10/15, through 10/26/15, included the following evidence of education provided to R56 in relation to her diabetic diet and/or concerns of noncompliance with her diet:	21475		

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21475	Continued From page 86 On 9/15/15, at 8:25 p.m. LPN-D noted, "... noncompliant with [diabetic] diet; spouse in to visit with resident this evening; brought in PB [peanut butter] sandwich, 2 [two] bags chips and soda for resident all of which she ate for HS [bedtime] snack." On 9/16/15, at 4:21 p.m. registered nurse (RN)-C noted, "[R56] would like to talk with the dietician regarding her meals. Message left with manager." On 9/17/15, at 9:13 a.m. certified dietary manager (CDM)-A noted, "Sat down with resident at breakfast and discussed her diet. Resident was unsure of what she was supposed to eat and how to order on a diabetic diet. We talked about 4-5 carbs [four to five carbohydrate choices] a meal and to go for healthy carbs like fruits vs [verses] the chips and pop. We spoke about sugars and I gave her some reading materials on diabetes. I also gave her a mini meal cheat sheet to help her order and still be in her carb count." On 9/17/15, at 9:15 a.m. CDM-A noted her initial nutritional assessment for R56. The assessment included, "Resident is currently on a Diabetic diet. She is independent with eating once a staff member has set her up. Her intakes are 76-100%. She is independent with her ordering and has been counseled as to how many carbs to have per meal and to watch her sugar intake. Also for HS snacks to try to have a half sandwich and small milk. She has been having a hard time with her choices for snack... Will provide diet per order and monitor weights and intakes for changes." On 9/21/15, at 12:00 a.m. LPN-I noted, "Appears noncompliant with diet ie: drinking large coke and numerous snack wrappers in trash. Encouraged... to not drink coke as that might be causing hi BS [high blood sugars]. Verbalized understanding and then proceeded to drink coke."	21475		

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21475	Continued From page 87 On 9/23/15, at 11:12 a.m. LPN-F noted, "Resident is not compliant with dietary needs. Although resident does usually choose to eat sugar free items, resident eats a lot of carbs... Resident has a large amount of sugar free candies in her room." On 10/13/15, at 10:42 a.m. LPN-F noted, "Resident has been snacking on chips today et [and] yesterday morning et afternoon." On 10/15/15, at 5:24 p.m. LPN-J noted, "Resident left facility again to go out to eat with her husband to KFC and will r/t [return] later tonight." On 10/21/15, at 2:07 p.m. LPN-F noted, "Resident has been provided reminders of appropriate meal selections for snacking." On 10/22/15 at 1:20 p.m. LPN-F noted, "Resident's husband here et took resident out at lunchtime." On 10/22/15, at 11:05 p.m. LPN-D noted, "Resident noncompliant with DM [diabetic] diet. Has variety high carb, high sweets in room; reviewed diabetic choices; resident stated 'ya, but I like these.'" On 10/23/15, at 123:32 p.m. RN-H noted, "Appetite is good; continues to snack frequently on high carb snack food. Was seen today by [primary medical doctor], and counseled about diet." On 10/24/15, at 8:48 a.m. LPN-J noted, "Continue to educate on her diabetes and food choices." During interview on 10/23/15, at 7:33 a.m. RN-H reported R56 had a seizure earlier that morning, prompted by hypoglycemia. She stated, though R56 had not had a seizure since admitted to the facility, she did have a history of this occurring when she lived at home. RN-H reported a seizure from hypoglycemia was what had resulted in the hospitalization just prior to her admission to this facility. RN-H stated R56's blood sugars were	21475		

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21475	Continued From page 88 extremely erratic and that they wient way high, then way low. She said that R56 was non-compliant with her diet and this had been a longstanding issue from prior to her admission. She stated facility staff talked with her frequently about her diet and educated her on what she should or should not have been eating, but they had to honor her right when she declined to let them take snacks out of her room. RN-H stated R56's husband was bringing lots of snacks in for her. She added, facility staff tried to educate him all of the time, with no success. During interview on 10/23/15, at 12:38 p.m. nurse practitioner (NP)-B expressed concerns regarding R56's diet non-compliance. When asked whether R56 had the capacity to make an informed decision about her diet he responded, "No. And that is why we are trying our best to get her in a group home." NP-B added, he and R56's primary medical doctor had a meeting the week prior, with the Wright County case manager/ social worker SW-D, who was assigned to R56's case. The discussed discharge planning options for R56 as she was scheduled to discharge from the facility the following week. He stated, SW-D wanted to allow R56 to return home, with additional in-home services. However, he stated, "Last time [they] tried that, she turns them away, tells them to leave and go home." NP-B stated R56 historically did not allow in-home service providers to actually provide the support necessary. NP-B reported, "Really the only way to get her to follow her diet would be to commit her." He stated R56's husband, also did not have the capacity to make decisions on her behalf. He stated he was unsure of whether SW-D was pursuing guardianship at this time. NP-B stated he and R56's primary medical doctor were working very hard to find a working plan. NP-B stated the facility staff needed	21475		

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to honor R56's choice if she would not allow them to remove the snacks from her room. He stated he was not surprised to learn snacks of chips and soda pop were observed in her resident room throughout the week.

During observation and interview on 10/23/15, at 1:00 p.m. R56 denied facility staff had talked with her about how to make meal selections within the confines of her diet. However, she stated they did talk to her about what kind of snacks to choose. She stated they told her to eat peanut butter with bread and fruit. R56 stated she would have allowed the staff to remove snacks from her room if they wanted to. She denied having been asked if they could remove snacks from her room. R56 stated she knew how to make food selections in compliance with her diabetic diet. She stated she ate what she wanted to eat and routinely went out to eat with her husband. Several snack-sized potato chip bags were observed on a chair in R56's resident room. Each of the bags were opened, with approximately half of the contents remaining. R56 affirmed her husband routinely brought snacks into the facility for her.

During interview on 10/26/15, at 9:06 a.m. SW-A sated she had noted R56 as potentially requiring a PASRR level 2 when she did her pre-admission screening before she was accepted as a new admission, "but then she ended up coming across as not being a level 2." SW-A stated Senior LinkAge Line ® typically contacted the facility when a level 2 evaluation was required, then a county worker typically came out to the facility to complete the level 2 screening. SW-A reported she did not know if it was the facility's responsibility to follow-up if the county did not come out. When asked whether R56 had a diagnosis of developmental disability, SW-A

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stated she did not see any diagnoses in her medical record to support this. She stated the hospital told her R56's county case manager was very involved and there was discussion of potential placement at a group home. SW-A stated, "If you talk with her and are around her it seems like there would be a DD diagnosis." SW-A confirmed she was not involved in assisting R56 with her diabetes management or compliance with her diet. She had provided no consultation with regard to adaptations for education materials or approaches to enhance R56's comprehension of her dietary needs. At the time of interview, SW-A was handed a large bag of chips from another facility employee. She stated it was 'contraband' from a resident who was not supposed to eat that type of food. She stated that it was part of that resident's plan, for staff to check his room for contraband and remove anything found. When asked whether there had been any consideration for a similar arrangement to be made for R56, SW-A stated that the other resident had cognitive disabilities which limited his ability to make appropriate diet choice, but R56 did not have any such diagnosis and therefore, she did not have the authority to implement such a plan. SW-A confirmed she had not coordinated with the county case manager to identify any social service needs for R56.

During a telephone interview on 10/26/15, at 9:41 a.m. SW-D stated R56 had received in-home services from an independent living skills (ILS) provider who tried over the past year to help R56 develop a calendar or book to track what she was eating. SW-D stated the ILS services had not proved successful and that R56 did not appear to have the capacity to comprehend the risks associated with failing to comply with her diabetic diet. SW-D stated she did believe R56 required

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specialized support to work with her on compliance with her diet. She reported R56 "definitely" required more one-on-one attention and the county was currently considering the pursuance of legal guardianship. When asked about R56's diagnoses, SW-D stated there was some indication of a learning disability, but she did not see anything in her record identifying an actual diagnosis of developmental disability. However, as the conversation progressed, SW-D mentioned some psychological testing that was completed for R56 approximately six months prior. Upon further inquiry, SW-D stated the testing identified an intelligence quotient (IQ) of 63 and included a notation of moderate intellectual disability. A Psychological Interpretive Report signed 3/25/15, detailed assessment and psychological testing that was completed on R56 at Nystrom & Associates, Ltd by licensed psychologist (LP)-A. The report detailed R56 had a Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), full scale IQ of 63, with a resulting diagnosis of moderate intellectual disability.

During interview on 10/26/15, at 1:59 p.m. RN-H stated R56 had a long history of fluctuating blood sugars. She stated, on 10/23/15, when R56 had a hypoglycemic event, the police and paramedics who arrived at the scene were familiar with R56 and had indicated a history of responses to similar calls when R56 lived at home. RN-H stated facility staff had done education with R56 and her husband regarding her snacks. However, she added, "...as of right now she is her own person and she can make those decisions." When asked whether R56 had the ability to understand the risks of non-compliance with her diet, RN-H stated, "Hard one to answer... because the only real diagnosis we have is the

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21475	Continued From page 92 bipolar disease... I think there is some cognitive impairments with her... Maybe a group home or foster home would be a better option, but guardianship is not in place yet." RN-H was asked what adaptations, if any, had been made to the verbal education and education materials provided to R56, to optimize her understanding. She replied she was unsure whether any adaptations had been made. However, she added, "Mainly it is more the staff reminding her... When it's snack time she does have a sandwich and dietary is involved at meal times. When dietary staff take her order they can make recommendations on healthier options." During interview on 10/26/15, at 4:56 p.m. the DON stated the facility's social service department was responsible for overseeing the PASRR process. She stated she did not believe there was anyone in the facility who required a PASRR level 2. She stated she was not aware R56 had a diagnosis of intellectual disability. She stated, "If I had known... yes, we would try to work with her where she is at." The DON reported she was unsure whether facility staff had made any adaptations or provided any kind of specialized support to R56 with regards to her diet. She added, "Her diabetes is so significant, she has some needs that I think are a little different... we do what we can to identify them... I would expect the social worker to be coordinating that [any specialized supports] and then nursing interjected into that." A facility policy addressing the responsibilities of social services was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review	21475		

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LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21475	Continued From page 93 and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director	21530		12/29/15

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21530	Continued From page 94 of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist recommendations to establish pain medication parameters for use were acted upon for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, no pain, and required extensive assistance with his activities of daily livings (ADLs). The MDS identified R5 had diagnoses including chronic osteomyelitis [an infection of the bone or bone marrow] and a non-pressure related foot ulcer. R5's signed Physician Order Report dated	21530	Corrected.	

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21530	Continued From page 95 10/6/15, identified medication orders for pain including the following: "Acetaminophen [medication used to treat pain and inflammation] tablet; 650 mg [milligrams] ... DX: [diagnosis] pain ... Every 4 Hours - PRN [as needed]." "Tramadol [narcotic-like pain reliever] - Schedule IV [four] tablet; 50 mg; ... Every 6 Hours - PRN." The signed physician orders did not provide or identify any parameters or direction for when nursing staff should administer the Acetaminophen versus the Tramadol to help control R5's pain. R5's Consultant Pharmacy Drug Regimen Reviews directed the following, "Potential by [sic] insignificant problem," to be acted upon by facility staff: 8/3/15 - " [#5] Please check if there are parameters for using prn Acetaminophen vs [versus] Tramadol?" 9/2/15 - "Repeat MMR [medication regimen review] 8/3/15 #5 - if not addressed." 10/1/15 - "Repeat 8/3/15, MMR #5. Does not appear to be addressed." R5's medical record was reviewed and there was no evidence the consultant pharmacist's recommendations were acted upon as requested on 8/3/15, 9/2/15, and 10/1/15, to assist in clarifying the parameters for R5's pain medication regimen. During interview on 10/26/15, at 9:36 a.m. licensed practical nurse (LPN)-A stated she would provide either of the medications to R5 based on how much pain he would complain of, however,	21530		

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21530	Continued From page 96 she stated established parameters would ensure staff were treating R5's pain consistently. LPN-A reviewed R5's EMAR (electronic medical administration record) and stated there were no established parameters for R5's as needed pain medications. During interview on 10/26/15, at 9:54 a.m. registered nurse (RN)-A stated the nursing staff reviews the pharmacists recommendations after each visit and updates the physician with the pharmacy recommendations. RN-A reviewed R5's medical record and stated the recommendation by the pharmacist to establish parameters for R5's as needed pain medications was not addressed, and stated the recommendations should have been followed up on, "That's an issue." During interview on 10/26/15, at 11:14 a.m. the consulting pharmacist (CP) stated he allows facilities a certain time period for staff to address his recommendations, however, the facility should have addressed the recommendations made on 8/3/15, 9/2/15, and 10/1/15, and stated, "It should be done." A facility policy on medication regimen review and management was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The medical director, consulting pharmacist and/or their designees, could review and/or revise facility policies and procedures related to medication regimen reviews and response to resulting recommendations. Responsible personnel could be re-educated on these policies and procedures. The medication regimen of the individual(s) identified in the deficiency could be	21530		

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21530	Continued From page 97 reviewed with recommendations discussed and acted upon and supporting documentation maintained. Consulting pharmacy recommendations for other residents could be evaluated for appropriate response. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		12/29/15

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21545	Continued From page 98 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 1 residents (R45) who had a medication error in which they received the incorrect dosage of insulin that caused low blood sugars with physical symptoms. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated the resident was cognitively intact, had diagnoses of diabetes mellitus, and received daily insulin injections. Review of the Buffalo Clinic Telephone order report dated 4/8/15, indicated the facility was instructed by the clinic to notify the physician if	21545	Corrected.	

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21545	Continued From page 99 R45 had blood sugars below 80 milligram/deciliters (mg/dl), normal blood sugar range 80-120 mg/dl. Review of the Allina Health Clinic Buffalo note which included physician orders dated 4/16/15, indicated R45 was to, "Continue Lantus [long acting insulin] as of the last dosage which was 37 units in the morning. No night time dosage for now." The Lake Ridge Care Center signed Physician Order (PO) Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. The PO did not direct staff to give a night time dose of Lantus. An Allina Health office visit note dated 4/20/15, indicated R45 was to go, "Back on lantus 37 units at bedtime." However, there was no indication R45 had been receiving Lantus at bedtime prior, as the resident had only been taking Lantus 37 units in the morning. Although this PO added 37 units more of insulin, than R45 was currently receiving. The facility did not clarify the significant increase in insulin R45 was to receive from the Allina physician. Review of R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in the morning. However, on 4/20/15, Lantus at HS (at bed time), was implemented, along with the Lantus 37 units in the morning; doubling R45's dose of insulin. The Diabetic Administration History report indicated R45 received Lantus 37 units at HS from 4/20/15, to 4/26/15. Review of R45's Lake Ridge Care Center Vitals Report identified on 4/22/15, at 7:44 a.m. R45's	21545		

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21545	Continued From page 100	21545		

blood glucose was only 52 mg/dl (milligrams per deciliter). Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15.

R45's Resident Progress Note dated 4/25/15, indicated the residents blood glucose was checked when the resident was eating breakfast and was only 51 mg/dl. Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15.

R45's Resident Progress Note dated 4/26/15, at 3:30 a.m. indicated the residents blood glucose was 51 mg/dl. Review of the medical record did not indicate the physician was notified of the low blood sugar, nor did the facility identify the residents insulin had been doubled on 4/20/15.

R45's Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated, "Resident had low BS (blood sugar) this morning; was sweating and shaky. She had a BS of 38." The physician was called at 8:44 a.m. and updated on R45's low blood sugar.

A Buffalo Clinic Telephone Communication sheet indicated on 4/27/15, at 8:42 a.m. Lake Ridge called the clinic regarding R45's low BS in morning of 38 mg/dl. The Telephone Communication form indicated at 4:46 p.m. Lake Ridge called the clinic back wanting to know if the patient should actually be on 37 units of Lantus at bed time, as the facility just noticed the insulin orders did not match up.

A Buffalo Clinic Telephone order report dated 4/27/15, medical doctor (MD)-B indicated at 5:34

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21545	Continued From page 101 p.m., "Discussed with [staff] by phone. As of 4/20/15, visit had written to return to Lantus 37 units at bedtime, when it should have been once daily MORNING DOSE> Clarified with [staff] patient has been receiving lantus 37 units twice daily since the last visit with recent low blood sugars." MD-B ordered Lantus 37 units once daily in the morning as prior to hospital stay. R45's Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated, "Resident had been receiving Lantus 37 units BID (twice daily) since 4/20, miscommunication written upon return from appointment. Spoke with [MD-B] and the HS dose has been d/c'd [discontinued] and will continue the 37 units in AM (disregard previous T.O. (telephone order)." During interview 10/26/15, at 9:30 a.m. director of nursing (DON) stated she was not aware of the insulin medication error that had occurred for R45, and stated she was unable to locate a medication error report. The DON stated the nurses should have called the physician when they noted the order for Lantus to be given at HS on 4/20/15, since the resident had not received that dose before, and the order was doubling the current insulin she was receiving. The DON stated that she had not checked any other residents orders to see if this was reoccurring problem. DON stated she did not do any staff training related to the significant medication error, because she was not aware the error occurred until survey on 10/26/15, six months after the error occurred. Although R45 was previously on Lantus 37 units in morning only, and had a history of low BS after the order to double the residents insulin dose on 4/20/15, the facility failed to clarify with the	21545		

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21545	Continued From page 102 physician the additional order of Lantus 37 units at HS, nor did the facility contact the physician when R45 had low blood sugars on 4/22/15, 4/25/15, and 4/26/15. The facility did not contact the physician until 4/27/15, 7 days after R45's insulin dose was doubled, when the resident had a low blood sugar of 38 and experienced symptoms. Also, there was no indication they looked at other residents, and educated staff to prevent other potential medicaiton errors. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to medication administration, preventing significant medication errors and/or medication transcription processes. Responsible personnel could be re-educated on these policies and procedures. The medication regimen for the individual(s) identified in the deficiency could be reviewed for accuracy and appropriateness, with supporting documentation maintained. An investigation could be completed to determine the root cause of this significant medication error, with corrective action implemented to prevent similar errors from occurring in the future. The medication regimens of other residents could be evaluated for appropriate transcription processes and administration. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21545		
21665	MN Rule 4658.1400 Physical Environment	21665		12/29/15

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21665	Continued From page 103 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety was assessed and interventions were implemented for 1 of 1 residents (R73) who spilled hot coffee on himself while attempting to carry the coffee between his legs and obtained nine second degree burns to his lower left extremity. This resulted in immediate jeopardy for R73, who remained at risk of serious injury when the facility failed to assess safety with hot beverages and implement interventions to prevent similar injuries. The immediate jeopardy began on 10/10/15, at 4:50 p.m. when R73 obtained nine second degree burns (blistering with partial thickness) to his lower left ankle and foot from the spilled hot coffee, and the facility failed to complete an assessment and implement interventions to prevent reoccurrence. On 10/21/15, at 6:06 p.m. the facility administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for R73. The IJ was removed at 10/23/15, at 8:24 a.m. but noncompliance remained at an isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, identified the resident had no cognitive impairment, required extensive assistance for	21665	Corrected.	

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21665	Continued From page 104	21665		

bed mobility, transfers, locomotion on the unit, dressing, and toilet use. R73 required supervision with eating and had bilateral, functional limitations in range of motion, to both upper and lower extremities.

R73's Care Area Assessment (CAA) dated 10/1/15, indicated R73 was at risk for falls due to weakness from Friedrich's Ataxia (a disease which caused progressive damage to the nervous system and manifested as poor coordination, spasticity in lower limbs, muscle weakness, and absent lower limb reflexes), with a history of numerous falls at home, and one fall since admission to the facility. The CAA indicated R73 required assistance with transfers, however, required reminders from staff to wait for help.

A Fall Scene Investigation Report dated 10/10/15, at 4:50 p.m. indicated another (unidentified) resident's family member witnessed R73 fall from his wheelchair in the facility's lower level, between the vending machines and the rehabilitation dining area (hillside room). The report indicated R73 was holding coffee just prior to the fall, and lost strength, or appeared to become weak, and fell to the floor out of the wheelchair. When R73 was asked what he was trying to do just before the fall, R73 stated he had gotten a cup of coffee out of the vending machine. The report indicated R73 was alert and orientated, wearing shoes, and had recently received narcotic medication. The review indicated environmental factors related to the fall were hot coffee and R73's physical condition or diagnoses as contributing factors to the fall. The report indicated, "Resident is unable to carry hot item in [an] unsafe cup. Ask staff for help." The root cause of the fall identified, "Resident did not have the strength to hold [an] unsafe paper coffee cup." The Fall Scene

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21665	Continued From page 105 Investigation Report did not identify if the resident and staff were educated regarding the need for R73 to be assisted with obtaining coffee out of the vending machine, nor was there an assessment of the residents wheelchair related to the ability of R73 to safely carry the hot coffee to prevent further injury. An Event Details report dated 10/10/15, at 5:55 p.m. indicated, "Res. [R73] states his body went spastic as a reaction to the hot coffee pain on his foot- it is part of his disease process that made him stiffen to come out of his wheelchair and fall to the floor. Res. [R73] is able to get around the facility ad-lib [at will]... and make his own decisions based on his judgement for how to spend leisure time. Care plan was followed as assessed... Treatment continues to heal the burn sustained in this event." Another Event Details report dated 10/13/15, documented at 1:20 a.m. noted R73 had obtained a skin injury on 10/10/15, described as, "Blisters left foot r/t [related to] coffee spill." The report identified multiple burns to the circumference of his left ankle and the top of his left foot, with moderate serous drainage and pain present at the injury site. Characteristics of the skin injury indicated blisters, light redness of skin, and superficial burns (injury to top layer of skin-epidermis). R73's activity at the time of injury was identified as, "Fell forward with hot coffee in hand," and poor upper body control was noted as a possible contributing factor to the fall/ burn. The skin injury dimensions to the left ankle and foot were detailed as follows: Site 1- 1.5 centimeters (cm) by (x) 2 cm, oval Site 2- 1.5 cm x 2 cm, oval Site 3- 0.5 cm x 0.5 cm, circular Site 4- 0.5 cm x 0.5 cm, circular	21665		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 106 Site 5- 3 cm x 2 cm, no shape noted Site 6- 6 cm x 6 cm, oblong Site 7- 2 cm x 2 cm, no shape noted Site 8- 3 cm x 2 cm, no shape noted Site 9- 3 cm x 3 cm, no shape noted R73's nursing progress notes were reviewed from 10/10/15, through 10/21/15, and indicated the following: 10/10/15, at 5:14 p.m. licensed practical nurse (LPN)-B indicated staff were alerted R73 had fallen out of his wheelchair. R73 was found lying on the left side of his body and partially on his back. No injury was obtained from the fall, however, when R73's wet clothes were removed, multiple, popped blisters to the left foot were found, and redness was also noted to both of R73's thighs from the coffee spill. On 10/12/15, at 4:01 p.m. LPN-C indicated a physician order had been obtained for Keflex (an antibiotic medication) 500 milligrams (mg), twice daily for R73's left foot burn. On 10/13/15, at 1:50 a.m. LPN-D indicated the blisters to the top of R73's left foot were intact and fluid filled. The blisters to the lateral, medial, and posterior sides were noted as opened. On 10/14/15, at 1:24 p.m. registered nurse (RN)-A indicated the dressing to R73's left foot burns was changed and, "Blisters on top of foot, on the inner ankle region, and outer ankle region, most of the blisters have popped at this point. Whole foot is swollen, red, and covered with freshly popped blisters. Inner ankle blister is still intact at this point. Patient denies pain to this area." R73's nursing progress notes had no assessment related to R73's safety related to safely carrying coffee after obtaining it from the vending	21665		

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machine, there was no indication R73 was educated on asking for staff assistance, nor was there evidence staff had been educated on ensuring R73 was monitored and assisted with coffee to prevent further burns.

R73's care plan dated 10/16/15, identified a potential alteration in skin integrity related to his being wheelchair bound, ataxia (loss of full control of body movements) and medication use. The care plan noted, "At risk for skin tears, etc.. Lt. [left] foot burn from hot coffee spill 10/15." The care plan goal was for the burn to heal without further complications, with interventions including the following: Treatments as ordered by the physician, Wound Care Standing Orders were to be followed as needed and as appropriate for skin issues, lotion as needed to moisturize skin, changes in skin were to be monitored with cares and as needed, a pressure reduction cushion was to be used in his wheelchair, a pressure reduction mattress was to be used on his bed, skin checks were to be done with bathing and as needed, and tissue tolerance testing was to be done per the facility policy to monitor for skin risk, with reassessments of skin risk as needed. The care plan also identified R73 as at risk for falls related to generalized weakness, and fall interventions included assessing his risk quarterly and as needed, monitoring for safety and assisting with mobility as needed, preventative measures of removing the hoyer sheet after use, and physical therapy as ordered and as needed. The care plan did not address R73's safety with hot beverages, transportation of hot beverages, or how to minimize his risk for burns/ injury similar to that which occurred on 10/10/15.

The undated nursing assistant (NA) care sheet (identified as what the NAs use to know specific,

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individualized resident care needs), lacked any information regarding R73's burn, or direction of safety interventions to minimize the risk for burns/ injury, similar to that which occurred on 10/10/15. There was no indication staff had been educated to ensure R73 was provided assistance when obtaining coffee out of the vending machine and utilizing a safe cup to prevent further burns.

During interview on 10/20/15, at 9:44 a.m. director of nursing (DON) stated on 10/10/15, R73 had gotten a coffee from the facility vending machine and spilled coffee, which led to a fall from his wheelchair as a reaction to the spilled coffee.

During observation and interview on 10/21/15, at 9:21 a.m. R73 was lying in his bed. His left foot was wrapped in gauze. R73 stated he had multiple burns on his left foot from spilling coffee. R73 stated he had purchased coffee from the vending machine downstairs in the facility and was propelling his wheelchair and his wheels were grasped somewhat suddenly on the floor, and his coffee spilled which he was carrying between his leg, and the coffee spilt into his boot on his left foot. R73 stated when it happened he had severe pain, however, the pain has gotten better. During this observation, R73 was observed getting a needle nosed pliers from his belongings nearby and used it to lift the tab of his Mt. Dew pop can in order to open the can. R73 held the pop can inside a can coozie, and when he took sips of his pop he lifted the beverage up to face level, and raised his neck to bring his mouth to the lip of the can.

On 10/21/15, at 2:30 p.m. the DON recorded the following progress note, "When writer asked, [R73] stated he... will not be using the coffee

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vending machine alone. 'I'm not going to do that again.' ...Business Office Manager took [R73] for a walk outside for fresh air and sun light in effort to help increase his mood." There were no other progress notes since the coffee burn occurred on 10/10/15, to indicate any interventions were put into place to ensure R73 did not obtain further burns from the facility coffee vending machine.

During a follow up interview on 10/21/15, at 3:21 p.m. R73 stated he had just recently gone downstairs prior to this interview and was looking at the flavor selections offered from the facility coffee vending machine. R73 stated he wanted to try some of the flavored coffees out of the vending machine. However, he stated as he was determining what kind of flavored coffee he wanted, the (unidentified) business office employee told him he was not allowed to get coffee out of the coffee machine anymore so he would not get burned again. R73 stated he then asked an unidentified dietary staff downstairs if they could help him to purchase a coffee from the vending machine and they said no because they were not allowed to handle resident money. When asked why he could not have made the coffee purchase, but had the staff simply assist with retrieving and transporting the coffee for him, he stated he had not thought of trying that arrangement. R73 stated he was capable of putting his own money into the machine and getting his own coffee out of the vending machine. During this interview R73 was observed seated in his wheelchair in his resident room. His wheelchair had no arm rests, and there were no adaptations to the wheelchair to aid in holding a beverage or any other item. R73 was observed self propelling his wheelchair with his hands and his feet were on the footrests, and his left foot remained wrapped in white gauze.

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21665	Continued From page 110 During interview on 10/21/15, at 3:21 p.m. dietary aide (DA)-B stated she was not aware any residents had been burned by coffee, and had not been told R73 needed to be provided assistance, needed any monitoring, or required any special interventions in place related to obtaining coffee out of the vending machine located outside the dining room. During interview on 10/21/15, at 3:21 p.m. cook (C)-B stated she had seen R73 using the facility coffee vending machine in the past. C-B had not been told there were any residents who should not be using the coffee vending machine, nor was she aware R73 had experienced burns from the coffee on 10/10/15. During interview on 10/21/15, at 3:28 p.m. NA-B stated she referred to the NA care sheet for direction on what individualized cares and interventions were needed for each specific resident, and stated the care sheets were updated daily by the clinical coordinators with any changes in care. NA-B stated the nurses also told the NAs of any significant changes with residents. NA-B stated she was not aware of any residents who had received coffee burns, nor was she aware of any special interventions in place for R73 related to drinking hot beverages or requiring supervision and/ or assistance to obtain coffee from the vending machine. During interview on 10/21/15, at 3:30 p.m. NA-C stated she was aware R73 had a burn on his foot from spilling coffee, however, she stated there had been no changes to his plan of care, nor was staff provided any education regarding R73 carrying, obtaining, or drinking coffee from the vending machine.	21665		

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21665	Continued From page 111 During interview on 10/21/15, at 3:41 p.m. NA-D stated she was aware R73 had purchased a coffee from the vending machine downstairs and burnt himself. NA-D stated staff were to watch him with coffee or hot liquids, however, she stated she could not control where he went when she was in rooms taking care of other residents, and stated, "He [R73] can do what he wants." NA-D stated there was nothing specific on R73's NA care sheets related to coffee or hot liquids. During interview on 10/21/15, at 4:07 p.m. DON stated R73's burn happened on a weekend, and confirmed that all the information, reports, assessments, interventions, and investigation related to R73's coffee burn had been provided, and the event report contained all the information for the facility investigation and the interventions. The DON stated R73's physician and family were notified of the burns, and orders were obtained for treatment of the burns. The DON stated she talked to R73 about the burn, and the resident told her he was, "Never going to touch that coffee machine again." The DON stated the intervention to prevent further injury from coffee burns for R73 was to speak to him about not using the coffee vending machine again. The DON stated R73's care plan was updated to address the fall that happened as a result of the burn, but no interventions had been put into place to prevent R73 from burning himself with coffee again, other than the discussion she had with the resident telling him not to use the vending machine again to get coffee. The DON stated she was not aware R73 was downstairs earlier this day wanting to purchase another coffee from the vending machine. She stated she was aware R73 was downstairs earlier with the business office manager (BOM) and had been emotional	21665		

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21665	Continued From page 112 about his placement at the facility, but was not aware R73 attempted to get coffee from the vending machine. The DON stated R73 was safe to "go out ad lib" in the facility, and the assessment of R73's safety after the burn was "just what I have documented here [on the event report] as a result," as well as the information she added earlier today to the nursing progress notes. During a follow up interview on 10/21/15, at 5:18 p.m. R73 stated he typically ate his lunch and supper meals in the main dining room. R73 stated he did not need to use any modified utensils or adaptive equipment for eating. R73 also stated he, "Stripped it [wheelchair] all down" himself, because he did not like having arm rests on the chair as it made it easier to propel the wheelchair with his arms/ hands. R73 stated his wheelchair needed to stay like it was so he was able to move himself around the facility. The facility's Wound Prevention and Treatment policy dated 6/14, directed individualized, preventative, interventions be developed based on the skin and risk assessments of each resident. The facility's Injury Documentation policy dated 6/14, directed documentation of injuries include an evaluation of contributing factors for the skin injury, a root cause of injury, and interventions in place. The care plan for skin integrity was to be reviewed and revised based on the resident's treatment and needs. The immediate jeopardy that began on 10/21/15, at 6:06 p.m., was removed on 10/23/15, at 8:24 a.m. when the facility completed the following interventions:	21665		

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21665	Continued From page 113 - The coffee vending machine was removed from the facility on 10/22/15. - R73 agreed to use a covered cup when drinking hot liquids, and the residents care plan was updated to ensure staff was aware of the safety intervention. - If R73 would like to transport hot beverages he has agreed to ask staff for assistance vs transporting it between his legs. - All residents in the building would continue to be monitored by dietary and nursing staff who had been trained to ensure resident needing adaptive/ safety equipment were assessed and provided the necessary adaptive equipment to ensure safety. On 10/23/15, from 7:45 a.m. to 8:08 a.m. direct care staff, including dietary staff were interviewed and explained their knowledge of ensuring R73 was provided a covered cup when drinking hot liquids, and would be assisted to transport any hot liquids he wished to take out of the dining room area. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to safety hazards/ hot beverages. Responsible personnel could be re-educated on these policies and procedures. The individual(s) identified in the deficiency could be re-assessed for safety risks and appropriate interventions could be implemented, with supporting documentation maintained. Other residents could be evaluated for similar risks, with interventions implemented. An auditing system	21665		

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21665	Continued From page 114 could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21665		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to	21800		12/29/15

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21800	Continued From page 115 vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R98) were provided the required notice of Medicare non-coverage upon termination of the covered services. Findings include: A facility Admission/Leave/Discharge Tracking Report dated 4/15/15, to 5/25/15, identified R98 was admitted with a payment source of, "Medicare Part A," and remained in the facility for 32 days. R98's medical record was reviewed, however, no information was identified she had been provided the required notices of Medicare non-coverage prior to her Medicare services ending. During interview on 10/26/15, at 2:14 p.m. social worker (SW)-A stated there was no documented evidence R98 was provided a Notice of Medicare Provider Non-Coverage (CMS-10123). R98 was admitted for a therapy stay at the facility, and should have been given the denial notice two days before her covered services ended. During follow up interview on 10/26/15, at 2:55 p.m., SW-A stated the facility did not have a policy on ensuring the liability notices were given correctly, rather they, "Just follow Medicare guidelines." SUGGESTED METHOD OF CORRECTION:	21800	Corrected.	

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21800	Continued From page 116 The social worker or designee, could review and/or revise facility policies and procedures related to liability and appeal rights notices for Medicare non-coverage. Responsible personnel could be re-educated on these policies and procedures. Appropriate notices could be provided for individual(s) identified in the deficiency, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting aftercares and ensure appropriate incontinence products were provided for 1 of 2 residents (R126) who expressed concerns of undignified care and services. Findings include: R126's admission Minimum Data Set (MDS)	21805	Corrected.	12/29/15

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21805	Continued From page 117 dated 9/25/15, identified R126 had intact cognition, required extensive assistance for toileting, and was "always" continent of bowel. R126's care plan dated 10/12/15, identified staff were to provide incontinence products for R126 as needed, and provide assistance from one staff for toileting, bathing and grooming. During interview on 10/20/15, at 3:22 p.m. R126 stated he was dependent on staff for assistance because he was unable to walk or get to his wheelchair by himself, which made him feel anxious and helpless. R126 stated he had waited for up to 30 minutes before to have his call light answered, which only increased his anxiety. R126 reported two instances of having "very close calls" with bowel incontinence because of having to wait for extended periods of time for assistance, and added he still required assistance to complete post toileting care after using the provided bed pan. R126 had a sore on his bottom that would become worse and painful if left on the bed pan too long, so R126 raises himself up from the pan and removes it, the sets himself down on newspaper he places on the bed to keep the linens from becoming soiled until staff could assist him with cleaning. R126 stated he felt this was undignified. R126's family member (FM)-D was present for the interview, and stated R126's statements of lack of toileting aftercare were accurate. On 10/23/15, at 7:03 a.m. R126 stated he had a bowel movement that morning, and again placed newspaper underneath of him when finished utnil staff were able to assist him with clean up. R126 became tearful, and stated, "I just feel so helpless." R126 continued to have visible tears in his eyes, stated he could not continue the interview, and requested the surveyor return later.	21805		

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21805	Continued From page 118 On 10/26/15, at 10:100 a.m. R126 stated he did not prefer to use newspaper underneath of him while waiting for staff assistance, but added, "That is how I have leaned to work with the system." He did have wetted wipes available, but he was unable to use them due to his mobility impairments, and the only option the staff presented to him versus using newspaper was to wear, "A big diaper." R126 stated he was never offerd a disposable chux (absorbent pads used to collect fluids). Again, R126 became teary eyed during the interview, and expressed frustration and feelings of helplessness, "I have no control over when they are going to come and help." When interviewed on 10/26/15, at 10:27 a.m. nursing assistant (NA)-A stated she had assisted R126 in the past with toileting cares, and seen soiled newspapers on his bed. NA-A stated she had never asked R126 about the soiled newspapers before though, and was unaware he was having to use it as a barrier until staff assisted him. During interview on 10/26/15, at 2:18 p.m. registered nurse (RN)-H stated R126 was always continent of bowel, and a commode at his bedside had been tried, but R126 tended to prefer the use of a bedpan over a commode. RN-H was unaware R126 was placing newspaper underneath of himself until being assisted by staff with clean up, and added several other products were available and could be used. Further, RN-H stated she expected staff to report it to her if R126 was observed using newspaper in that manner. During interview on 10/26/15, at 5:06 p.m. the director of nursing (DON) stated she was unaware R126 was using newspaper as a barrier	21805		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 119	21805		

to protect his bedding while waiting for staff assistance with clean up, but added it was a "innovative" solution. The DON stated disposable pads were not routinely used in the facility, but they could have been ordered for R126.

A letter submitted post survey exit, dated 10/27/15, authored by the DON and signed by the DON and R126 noted, "He [R126] states he uses his trapeze to pull his body up and place himself on the bedpan for a bowel movement, 'I can't reach to clean myself. The cover on the bed is white. I don't want to get it dirty so when I take the pan out I put the newspaper under my butt to keep from getting marks on the blanket. Then I put my light on for someone to come and get the pan and clean me up.' He went on to say that he knows we are busy and he can do some things for himself. As indicated with matching facial expressions and shoulder shrugs [R126] did not indicate that he was bothered or feel that his dignity was being comprised with this innovative self-action."

A letter submitted post survey exit, dated 10/28/15, authored by NA-T noted, "A couple of times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put himself on bedpan, notifying staff only when he was done."

A letter submitted post survey exit, dated 10/30/15, authored by NA-D noted, "[R126] chose to use newspaper under himself even though I told him he didn't need to do that and we would change linen if it got soiled. He continued to put newspapers under him."

A facility policy related to dignified care and

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21805	Continued From page 120 services was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to dignified care and services. Responsible personnel could be re-educated on these policies and procedures. Care practices for the individual(s) identified in the deficiency could be reviewed and/or revised for compliance with these policies, with supporting documentation maintained. Other residents could be evaluated for dignified care and services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.	21830		12/29/15

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21830	Continued From page 121 (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not	21830		

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21830	Continued From page 122 liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for choices. Findings include: R73's admission Minimum Data Set (MDS) dated	21830	Corrected.	

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21830	Continued From page 123 10/1/15, indicated he was cognitively intact, needed assist of two staff with bathing, and it was "very important" to be able to chose the method in which he was bathed. R73's care plan dated 9/25/15, identified he had been admitted in September 2015, but did not identify any preferences or assistance R73 required with bathing. R73's undated Nursing Assistant Care Sheet indicated he received a tub bath on Thursday by an outside agency. During interview 10/21/15, at 10:02 a.m. R73 stated hospice is to be giving me two baths a week and the facility is supposed to also be giving me two baths a week. R73 then stated, "I have only received two baths from the facility since I have been here." The facilities Mill Creek Bridge Weekly Bath and Vital List dated 9/21/15 to 10/22/15, identified the following: > The week of 9/21/15 to 9/27/15, R73 was not identified on the bath list. > The week of 9/28/15 to 10/4/15, R73 continued to not be identified on the bath list. > The week of 10/5/15 to 10/11/15, R73 was scheduled to receive four baths, but only had one bath documented as being completed. > The week of 10/12/15 to 10/18/15, R73 was again scheduled to receive four baths, but only had one bath documented as being completed. > The week of 10/19/15 to 10/22/15, R73 was scheduled to receive three baths, but only had two baths documented as being completed. The bath listing identified R7 received two baths from the facility and two baths from the outside agency, a total of 4 out of the 11 baths he should have received. During interview 10/23/15, at 9:15 a.m. nursing assistant (NA)-F stated the staff do the best they can, but added, "We do not have a bath aide and we just can't get all of them done so some of the	21830		

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21830	Continued From page 124 baths have been missed. That's all I can say." During interview 10/23/15, at 9:21 a.m. registered nurse (RN)-A stated R73 should have received his bath according to his choice adding if it was not documented on the listing, it was not completed. A facility policy on choices was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to resident choice and participation in planning of their bathing schedules. Responsible personnel could be re-educated on these policies and procedures. Appropriate accommodations could be made to honor the bathing preferences of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for preferences with regard to their bathing schedules. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21830		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced	21870		12/29/15

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21870	Continued From page 125 by: Based on interview and document review, the facility failed to provide timely follow-up to the resident council groups grievance as concerned with inadequate staffing in the facility. This affected 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. Findings include: During the recertification survey, the resident council minutes were reviewed and identified the following: The resident council minutes dated 7/28/15, indicated under nursing R27, R19, R45, "All feel we do not have enough nursing help due to how long it takes for their call lights to be answered. Writer [activity director (AD)] explained the difference between cutting hours due to census vs. [versus] being short staffed." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R19, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/12/15, from the director of nursing (DON) provided a response which identified, "There are times of the day and night when many residents are requesting assistance at the same time. We are getting to each one of them as quickly as possible we are adequately staffed. Some employees are new and work a little slower while they are learning." The resident council minutes dated 8/13/15, identified, "Updates on last meeting concerns" were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The	21870	Corrected.	

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21870	Continued From page 126 minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention too! Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes dated 9/29/15, identified, "Council members are concerned about staffing. Writer [AD] explained staffing. [R21] had concern about waiting to go to his meal for too long. Writer explained about the requirement for a NAR's [nursing assistant, registered] to be able to sit with residents who need assist to eat and that this way likely the reason he had to wait." There was no evidence the repeated concerns regarding inadequate staffing at the facility were addressed by the management team. During interview on 10/23/15, at 12:23 p.m. R45 stated she did not feel the concerns voiced during the council meetings were addressed, adding, "They are so short staffed here at the facility sometimes I have to wait 45 minutes for the staff to help me you see I am immobile and need help to get on the bed pan to have a BM [bowel movement] and when they are late, I can't wait so I have an accident in the bed and that is not pleasant for me." During interview on 10/23/15, at 9:30 a.m. the AD who stated she is in charge of the resident council meetings. AD stated, "The residents do complain about the staffing here and it's a problem everywhere. I let the DON know about their concerns. I always tell them we are trying and with so many residents sometimes you just have to wait."	21870		

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21870	Continued From page 127 Although R27, R19, R45, R35 and R21 had complaints of staffing on 7/28/15, their concerns continued at the 8/13/15 and 9/29/15 resident council meetings with no objective, measurable plan being identified to resolve there concerns of staffing. The facility Grievances and Complaints policy dated 1/12/12, indicated "it is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." The policy further indicated "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to resident council grievances. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts toward resolution of resident council grievances could be made, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights	21880		12/29/15

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21880	Continued From page 128 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance	21880		

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21880	Continued From page 129 procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to resolve an individual grievance for 1 of 1 residents (R45) who had expressed concerns over lift placement and bruising. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated R45 was cognitively intact and required assistance of two staff for transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously... Had concerns about lift with sling placement and bruising [R45] felt she wasn't taken seriously." The action form indicated it was given to the DON. The form indicated the director of nursing (DON) response: "[R45] was not feeling well and gets paranoid/depressed with illness. this writer did visit with her and that she down played the concern." During interview on 10/22/15, at 2:10 p.m. the DON stated she was aware of R45's concern but did not feel it was a big deal. The DON stated it was about the lift but never investigated if there was bruising or how the staff were transferring the resident. The DON had not implemented any actions in effort to resolve R45's concern with the lift.	21880	Corrected.	

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21880	Continued From page 130 During interview on 10/23/15, at 12:23 p.m. with R45 stated the staff did not always listen to her when she made a concern. R45 stated a few months ago when she was being transferred from her ceiling lift, the strap was not connected correctly and it slid down on her right arm, causing a skin tear and bruising. R45 was "irritated" because she "made a grievance in resident council", but didn't "think anything was done about it." A facility Grievances and Complaints policy dated 1/12/12, indicated, "It is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." Further, the policy indicated, "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to individual resident grievances. Responsible personnel could be re-educated on these policies and procedures. Grievances could be addressed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate response to voiced grievances. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.	21880		

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21880	Continued From page 131 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	21980		12/29/15

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21980	Continued From page 132 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator, state agency and thoroughly investigated for 3 of 5 residents (R45, R104 and R131) whose allegations were reviewed. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated she was cognitively intact and required assist of two staff with transfers. A Resident Council Action Form dated 8/12/15, indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously" R45 had "concerns about lift with sling placement and bruising," and, "felt she wasn't taken seriously." The form identified it was given to the DON who responded, "Res [resident] was not feeling well and gets	21980	Corrected.	

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	00714	A. BUILDING: _____ B. WING _____	10/26/2015

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21980	Continued From page 133 paranoid/depressed with illness ... did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern. The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any bruising on R45. During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was no indication the adminstrator and the state agency were immediately notifed, nor had an investigation been completed of the allegation. R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door and overheard a mans loud voice that was not resident yelling and swearing. Writer was unable	21980		

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21980	Continued From page 134 to hear what was all being said but did her the word "Fuck", and "your and Asshole" in an angry tone of voice. Writer immediately went into room with nurse and saw resident's family member (FM)-A was yelling at resident. Resident was asked if he wanted FM-A to leave. Resident said yes. FM-A was asked to leave several times by writer before he complied with leaving. FM-A at the time was holding up his phone that had a light and was pointed towards resident. Resident was asked if his FM-A was video taping him. Resident stated yes. Writer asked residnet if FM-A had his permission to do this and resident stated "no". Resident also stated that (FM-A) has, in the past, been physically abusive to him and has also threatened to kill him in the past while at residents home. Resident stated that FM-A had actually pushed him into a bonfire at residents home to try to kill him, and he still had the scars to show for it. Resident express that he didn't know if he wanted FM-A back here at the facility since he has been the only one that has been helping him. Resident also let writer know that FM-A now had keys to his home, truck and was refusing to give those back. FM-A told the resident, "you will have to break into your house if you think you are going back there". Resident also stated FM-A has his laptop and refusing to give that back. The investigation was submitted to the state agency on 7/01/15. During interview 10/26/15, at 6:13 p.m. with the DON who stated the incident should have been immediately reported and she did not know why it had been reported late. Although the incident occurred on 6/26/15, the facility did not report the incident to the administrator and state agency until two days after the incident, on 6/29/2015.	21980		

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21980	Continued From page 135 R131's quarterly MDS dated 2/25/15, indicated she was moderately cognitively intact and needed extensive assist of two with transfers. An Investigative Report dated 4/5/15, indicated that on 4/3/15 R131 had a, "exp. large discolored area to the lateral left breast" which measured 10 cm (centimeter) by 8 cm in size. R131 was reassessed for her ability to continue to be transferred in this type of device, and R131 was determined to require a hoyer lift for transfers. The administrator and the state agency was informed of the incident on 4/5/15 two days later and the investigation was submitted to the state agency on 4/13/15, 10 days after the incident occurred and identified the injury was from a mechanical lift. During interview 10/22/15, at 2:17 p.m. DON stated the investigation was sent late and didn't know why it was sent late "maybe it was a computer glich". Further, the DON stated because of the size and the location, the incident needed to be reported. Although the injury was noted on 4/3/15, the facility failed to inform the administrator and and the state agency two days later and the investigation was not reported until 10 days later. The facilities Vulnerable Adult Abuse Prohibition Policy and Procedure revised November 2011, indicated "Each employee is responsible to report suspected/alleged violations of resident abuse/neglect immediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing, or Social Worker. The administrator will be notified immediately by on of	21980		

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21980	Continued From page 136 the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to abuse prohibition. Responsible personnel could be re-educated on these policies and procedures. Reports of abuse/ neglect/ injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		

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2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with cares for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R73) reviewed for bathing choices, for 5 of the 48 residents (R27, R19, R45, R35 and R21) reviewed for group grievances, 1 of 3 residents (R5) reviewed for dental hygiene, and for 5 of 6 residents (R5, R64, R45, R19, and R126) reviewed for activities of daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R5, R73, R35, R123, and R27), 2 of 4 family members (FM-G, FM-H), and 13 of 13 staff members (NA-G, HK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed expressed concerns and complaints related to insufficient staffing. This lack of sufficient staff had potential to affect all 48 residents who currently resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING	2 800	Corrected.	12/29/15

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2 800	Continued From page 1 MET: *Refer to F241: The facility failed to ensure timely assistance with toileting aftercare's and failed to ensure appropriate incontinence products were provided, for 1 of 2 residents (R126) who expressed concerns of undignified care and services. *Refer to F242: The facility failed to honor bathing preferences for 1 of 3 residents (R73) reviewed for bathing choices. *Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. *Refer to F282: The facility failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. *Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 residents (R45, R19), and assistance with toileting was provided for 1 of 5 residents (R126) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. RESIDENT CONCERNS ABOUT STAFFING: R126's admission Minimum Data Set (MDS) dated 9/29/15, identified R126 had intact cognition, and required extensive assistance to complete ADLs. During interview on 10/22/15, at 3:22 p.m. R126	2 800		

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2 800	Continued From page 2 stated he had to wait up to thirty minutes to have his call light answered to receive assistance with cares. R126 stated he needed staff assistance to use the restroom and get into his wheelchair, and he never knew how long it would take staff to answer his call light and that made him feel, "Anxious," and "Helpless." During a follow-up interview on 10/26/15, at 10:00 a.m. R126 stated his preference was to use a commode for toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He stated, he need help to get on and off the commode, but is unable to get onto the commode alone, and has to wait for staff to help. R126 reported he would have much rather used a commode for toileting and not a bed pan, because he doesn't get as "messy," But staff does not respond to his call light for assistance timely to help onto the commode, so he has to use the bedpan and not the commode, which he prefers to use. R55's quarterly MDS dated 9/15/15, identified R55 had moderate cognitive impairment, and required limited assistance from staff for ADLs. During interview on 10/20/15, at 9:13 a.m. R55 stated she often had to wait for extend periods of time to get help to the bathroom, and was frequently incontinent because of waiting for so long. R55 stated the facility needed more staff to help residents with their cares, "They just don't have the people to work." R85's quarterly MDS dated 9/1/15, identified R85 had intact cognition, and required extensive assistance from staff to complete ADLs.	2 800		

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2 800	Continued From page 3 During interview on 10/20/15, at 10:03 a.m. R85 stated the facility had been, "Short of staff," for the past two or three months. R85 stated staff takes, "Quite awhile" to answer his call light to provide assistance with cares, and it had, "Been a big annoyance." R118's admission MDS dated 8/24/15, identified R118 had intact cognition, and required limited assistance from staff to complete ADLs. During interview on 10/21/15, at 11:34 a.m. R118 stated staffing seems worst on the weekend and in the evenings. R118 had a dressing change that needed to be completed, however, the resident had to wait over 6 hours for staff to complete this which caused the dressing to become saturated and drip fluids. R5's quarterly MDS dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 9:11 a.m. R5 stated the facility did not have enough staff, and staff would often complain about being short staffed to him, and at times R5 had stated there was only one nurse working for an entire shift. R5 stated his call light will take, "Fifteen to twenty minutes," to get answered, and was once left on the commode for, "An hour and a half," before staff came to provide assistance. R73's admission MDS dated 10/1/15, identified R73 had intact cognition, and required extensive assistance from staff to complete ADLs.	2 800		

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2 800	Continued From page 4 During interview on 10/21/15, at 10:55 a.m. R73 stated he had waited for nearly two hours in the past for staff assistance to go to bed and for his call light to be answered. R73 stated the staff are over worked and under staffed for the residents to be provided the necessary cares in the facility. R35's quarterly MDS dated 10/6/15, identified R35 had moderate cognitive impairment, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:29 a.m. R35 stated the facility staff worked short nearly all of the time, and there had been times R35 would have to wait to use the bathroom but was incontinent due to not receiving timely assistance from staff to get to the restroom. R123's admission MDS dated 10/15/15, identified R123 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 12:20 p.m. R123 stated she had waited for over an hour to get help to the restroom, causing her to, "Just use my diaper," which she stated made her, "Feel degraded." R27's quarterly MDS dated 9/22/15, identified R27 had intact cognition, and required extensive assistance from staff to complete ADLs. During interview on 10/20/15, at 10:24 a.m. R27 stated she had waited for over an hour to have her call light answered to receive assistance, and the facility needed to have more staff to provide	2 800		

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2 800	Continued From page 5 the cares the residents needed. FAMILY COMPLAINT'S ABOUT STAFFING: During interview on 10/21/15, at 11:31 a.m. family member (FM)-G stated they had visited their family member in the past and used the call light requesting staff assistance and "Waited, and waited, and waited," over twenty five minutes for staff to respond. There had been multiple occurrences of waiting for the call light to be answered, and FM-G stated, "It [long call light response times] concerns me." FM-G stated they had been told the owners of the facility felt they were "Adequately staffed," but stated she disagreed and the facility needed to add more staff to help residents with cares. During interview on 10/26/15, at 10:01 a.m. FM-H stated he had noticed oral cares were frequently not being completed because of the lack of staff at the facility. The call light had taken over one hour to be answered in the past, and was especially worse on the weekends. STAFF CONCERNS ABOUT STAFFING: During interview on 10/22/15, at 10:38 a.m. nursing assistant (NA)-G stated she felt the facility needed more staff to assist the residents with cares. NA-G stated the residents often complain about the long call light response time and lack of assistance they receive with cares. NA-G stated the scheduled baths and grooming (nail care, shaving) is not always completed because of the lack of staffing adding, "[staff] don't have enough time to take care of the residents." NA-G stated several staff had been	2 800		

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2 800	Continued From page 6	2 800		

injured attempting to care for two assist residents by themselves because, "There's not enough staff on to help us out." NA-G stated the facility administration tells staff they, "Are looking into it," but rarely help staff provide the resident cares to ensure they are being completed.

During interview on 10/22/15, at 10:53 a.m. housekeeping aide (HA)-A stated the nursing staff had been short staffed lately. The lack of staff had made residents have to wait for help for extended periods, and HA-A will often walk by rooms and hear residents asking, "Help me, help me." HA-A stated administration is aware of the concerns staff is unable to assist residents with cares, but they tell employees they are trying to add more staff, "But it takes time."

During interview on 10/22/15, at 1:23 p.m. NA-I stated the staffing at the facility was, "Not good," and there was frequently only one or two NA's on each hallway to provide cares to the residents. The residents frequently had to wait, and call lights were not answered timely because of the lack of staffing, "They [residents] don't get the care they should get." NA-I stated several staff members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves.

During interview on 10/22/15, at 1:36 p.m. NA-C stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff.

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2 800	Continued From page 7 During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing. NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed. During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering. NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We [staff] don't have time," to answer them. The administration had done nothing to help with cares, but "they expect" the floor staff to get the work done and only come onto the floor, "When you guys [state surveyors] are here." During interview on 10/22/15, at 2:53 p.m. licensed practical nurse (LPN)-F stated staffing is "Not adequate," to care for the residents and their needs, and she was quitting her position at the facility because she valued her nursing license, and felt it was being put in jeopardy because of the lack of staffing and poor care being delivered as a result. During interview on 10/23/15, at 7:07 a.m. LPN-B stated she felt the facility did not have enough	2 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 8 staff to provide the necessary care to residents, and residents had to wait to get up for the day, and families voice frustration to the staff regarding the suffering care as a result of the poor staffing. LPN-B stated she recalled some dressing changes weren't completed because the nurse did not have time because they were busy trying to help provide the necessary care for the other residents. During interview on 10/23/15, at 11:52 a.m. registered nurse (RN)-A stated staffing had been a "big issue" at the facility. The floor staff are short of help and the residents care was suffering overall. RN-A stated several staff had resigned because of the poor staffing, and administration had never asked the staff about changing hours to balance the work better, or asked for floor staff's input on how to handle the short staffing situation. During interview on 10/26/15, at 2:32 p.m. occupational therapist (OT)-K and occupational therapist assistance (OTA)-J stated the floor staff could use more help, and the biggest complaint they hear from residents was the lack of staffing and waiting, "Way too long for [call] lights," to be answered. OT-K and OTA-J stated they were not aware of any actions being taken by the facility to address the short staffing concerns. During an anonymous interview with a staff member (SM)-A, several issues were presented with concerns about the lack of staff in the facility. SM-A stated the staffing was, "bad" at the facility, and administration was pulling in people to work the past few days, "Because you guys [state surveyors] are here." SM-A stated they often go home after their shift and feel bad because they were unable to complete their jobs and care for	2 800		

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	00714	A. BUILDING: _____ B. WING _____	C 10/26/2015

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2 800	Continued From page 9 the residents, "The cares are just not good." SM-A stated several baths were scheduled for a recent shift, but only two of them were completed and SM-A was told by the director of nursing (DON) to sign the care sheets identifying they were completed. SM-A stated that made her, "Really upset," and stated administration helping with cares on the floor was not typical, and was only being done, "because you guys [state surveyors] are here." During an anonymous interview, SM-B stated, "People are quitting because of the staffing," and raised concerns about some shifts with only two or three staff on the floor to work and care for the residents. SM-B stated they spoke to administration regarding the concern of not having enough staff to complete timely toileting, baths, and grooming because of the lack of staff, however, nothing had been done to fix this. The facility LRCC (Lake Ridge Care Center) documents, which displayed the names of the staff working on the floor for each shift, dated 10/19/15, to 10/23/15, were reviewed. The document identified each unit of the facility (Oasis, Lake View Lane, Mill Creek Bridge, and Northwoods), and provided blank spaces in which a staff members name was written to identify were they were scheduled to work. > On the AM shift, 10/19/15, the Oasis unit had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods each had open spaces identifying no staff were scheduled to work; and were left with just one nurse and one NA for each unit. The document identified six of the thirteen spaces used to identify staff, to be blank.	2 800		

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2 800	Continued From page 10 > On the AM shift, 10/20/15, the Oasis unit again had no staff names identified as being assigned to work on the unit. Mill Creek Bridge and Northwoods had open spaces with no staff names written in. Both units continued with just one nurse, and one NA working on the floor providing care for the residents. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/21/15, the Mill Creek Bridge had no NA displayed, only having a nurse assigned to provide care to the residents. Northwoods had one nurse and one NA to provide cares to the residents. The document identified seven of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/22/15, the Lake View Lane had no nurse identified, and only one NA. Mill Creek Bridge and Northwoods again each only had one nurse and one NA identified as providing cares. The document identified six of the thirteen spaces used to identify staff, to be blank. > On the AM shift, 10/23/15, the Oasis unit had no staff name identified as being assigned to work on the unit, and the Lake View Lane did not have a nurse identified. The document identified five of the thirteen spaces used to identify staff, to be blank. On 10/26/15, at 5:06 p.m. the director of nursing (DON) stated, "Right now we are just stuck on the staffing. It is the driver of all the other evils." She stated, "We work with corporate HR [human resources] all the time... to get and retain good staff." The DON added, "I think that almost everything else that we've identified [as potential quality deficiencies] are tied into it [staffing	2 800		

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2 800	Continued From page 11 concerns]... There are so many things that would not be an issue if we had enough people on the floor." The DON stated the facility management was well aware of the facility's staffing shortage and the quality concerns resulting from insufficient staffing. DON stated the facility's staffing shortage began around the end of summer when students returned to college, and there were also eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new admissions, but stated they had delayed some admissions until later in the week when another resident was discharged. When asked whether the facility had identified or addressed concerns of residents who were not receiving baths or oral cares, DON stated, "This is one of the things that is tied to staffing... we were doing great until the first or second week of September... We are supposed to have a bath aide [but] have not had one since September... I think everybody is getting really good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided.	2 800		

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2 800	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from residents, employees and families. Interventions could be identified and implemented to remedy the insufficiencies identified, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		