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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2DG3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00469

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245301**

2.STATE VENDOR OR MEDICAID NO.
(L2) **358342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER MEMORIAL CARE CENTER**
(L4) **23028 - 347TH STREET SOUTHEAST**
(L5) **ERSKINE, MN** (L6) **56535**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/03/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
03/31

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

12.Total Facility Beds **68** (L18)
13.Total Certified Beds **68** (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
	68			
(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:
Lyla Burkman, Unit Supervisor 07/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/20/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245301 July 19, 2018

Ms. Judy Bernat, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

Dear Ms. Bernat:

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 June 29, 2018 the above facility is certified for:

68 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 68 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 19, 2018

Ms. Judy Bernat, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

RE: Project Number S5301027

Dear Ms. Bernat:

On June 12, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 17, 2018. (42 CFR 488.422)

- Civil money penalty. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 24, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 24, 2018. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 3, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 10, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 24, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 29, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on May 24, 2018, as of June 29, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 29, 2018.

However, as we notified you in our letter of June 12, 2018, 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 May 24, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to

the imposed remedies:

- Civil money penalty. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 24, 2018 be rescinded as of June 29, 2018. (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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2DG3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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2.STATE VENDOR OR MEDICAID NO.
(L2) **358342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER MEMORIAL CARE CENTER**
(L4) **23028 - 347TH STREET SOUTHEAST**
(L5) **ERSKINE, MN** (L6) **56535**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
03/31

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

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13.Total Certified Beds **68** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(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 :
Theresa Gullingsrud, HFE NE II 06/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/19/2018 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 12, 2018

Ms. Judy Bernat, Administrator
Pioneer Memorial Care Center
23028 - 347th Street Southeast
Erskine, MN 56535-9466

RE: Project Number S5301027

Dear Ms. Bernat:

On May 24, 2018, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** 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.

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 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, 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 May 23, 2018, 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 June 17, 2018. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F688. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F689. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 24, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 24, 2018. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 24, 2018.

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 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25 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, Pioneer Memorial Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 24, 2018. 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 August 24, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL CARE CENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535

(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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/20/17 - 5/24/17, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		6/29/18

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

Electronically Signed | 06/19/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245301	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL CARE CENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535

(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
E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide emergency generator test documentation in accordance with the 2012, edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 68 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: During the facility tour between 9:00 am to 1:00 pm on 5/21/18, record review revealed the weekly	E 041	Pioneer Memorial Care Center wishes to have this submitted Plan of Correction stand as its record of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies sanctioned by the Department of Health and Human Services. The plan of correction is prepared and /or executed solely as a requirement by the provisions of Federal and State Law.	

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E 041	Continued From page 3 visual inspection was documented as being completed only once a month. This deficient condition was confirmed by the Facility Administrator and Maintenance personnel.	E 041	The 2012,edition of the Life Safety Code (NFPA 101)section 9.1.3.1 and the 2010 edition of NFPA110 the Standard for Emergency and Standby Power Systems was reviewed with regards to the emergency test documentation for the generator. The facility identified this deficient practice could affect the safety of all of the 68 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Facility corrective action included: Re-education of the maintenance personnel on the time frames of the emergency generator testing and maintaining a daily log. Testing and recording the generator log on a daily basis will be completed by maintenance personnel. The Administrator or designee will audit the log 3x weekly for 1 month. Audits will be reported and reviewed by the QAPI committee.	
F 000	INITIAL COMMENTS On May 20, 21, 22, 23, 24, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at	F 000		

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F 000	Continued From page 4 F689. On 5/22/18, at 2:22 p.m. an IJ was called at F689 for R15 related to the facility's failure to comprehensively assess and implement interventions in order to reduce falls and prevent injury or death. The IJ for F689 was removed on 5/23/18, at 5: 30 p.m. after verification of a removal plan. An extended survey was conducted by the Minnesota Department of Health on 5/23/18, and 5/24/18. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		6/29/18

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F 582	Continued From page 5 charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the	F 582		

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F 582	Continued From page 6 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Skilled Nursing Advance Notice of Non-coverage notification form to 2 of 3 residents (R214, R36) upon discontinuation of Medicare part A benefits, as required. Findings include: R214's SNF [skilled nursing facility] Beneficiary Protection Notification Review (CMS-20052), completed by the facility, revealed R214's Medicare Part A services started 11/6/17, and the last covered day of Part A service was 12/15/17. The form indicated the "facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R214 remained in the facility after 12/15/17. Further record review revealed the facility had provided a NOMNC [Notice of Medicare Non-Coverage] (CMS 10123), however, a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) (CMS 10055) was not provided. R36's CMS-20052, completed by the facility, revealed R36's Medicare Part A services started 3/9/18, and the last covered day of Part A service was 4/19/18. The form indicated the "facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R36 remained in the facility after 4/19/18. Further record review revealed the facility provided an SNFABN (CMS 10055), however a NOMNC (CMS 10123), was not provided.	F 582	The Medicare notice of non-coverage CMS 10123 and the SNFABN (CMS 10055) were reviewed . The facility developed a policy which states if Medicare will not pay for skilled nursing or specialized rehabilitative services that the facility will inform the resident or his legal representative in writing about the potential liability for payment for non-covered services. If covered services end for coverage reasons, PMCC will issue: • NOMNC and a denial letter; or • NOMNC and the SNFABN; or only • the NOMNC The facility identified that any resident who has a Medicare Part A stay has the potential to be affected. The facility corrective action included re-educating the Social Worker on the use of the proper NOMNC ,denial letters, and SNFABN form by the Administrator on 6/19/2018. The Social Worker or designee will conduct audits of the Medicare Part A beneficiary advanced notice of non-coverage 3 x weekly for 1 month, 2 x weekly for 2 weeks and 1 x week for 1weeks. Results of the audit will be reviewed during QAPI.	

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F 582	Continued From page 7 On 5/21/18, at 10:48 a.m. the licensed social worker (LSW) stated it was her understanding she was to provide one or the other of the forms NOMNC or SNFABN, and not both, if applicable. LSW stated she had recently received training regarding the beneficiary notices and confirmed prior to the training, she had only provided the NOMNC form which she had modified to include questions regarding the residents' decision to request an appeal. LSW stated after the training she had thought the SNFABN form replaced all previous forms so she had only been providing the SNFABN. A policy regarding beneficiary notification was requested but not provided.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		6/29/18

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F 609	Continued From page 8 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 incidents of potential resident to resident abuse had been reported to the administrator and/or the State Agency (SA) for 3 of 3 residents (R24, R300, R23, R33) who resided on the secured unit and had been involved in resident to resident altercations. Findings include: Review of R24's Progress Notes (PN) from 11/9/17, to 5/22/18, revealed the following resident to resident altercations: #1: PN dated 11/9/17, 10:57 p.m. indicated on 11/9/18, a nursing assistant (NA) reported he had heard hollering, went to check and had found R24 leaving his room with blood on his right sleeve of his shirt and R300 hollering at R24 with a comb in his hand. R24 presented with a skin tear on right arm measuring 5.0 centimeters (cm) x 3.0 cm, irregular in shape. The progress note indicated R24 tended to hover over other residents trying to be of help to them which startled other residents causing them to lash out in anger. R300 was a resident who startled easily. Charge RN [registered nurse] notified, Unit coordinator	F 609	A review of the SOM policies and procedures for reporting alleged abuse and neglect was reviewed. The facility identified that all residents involved in resident to resident altercations had the potential to be affected. Facility corrective action included OHFC reports were filed for the alleged resident to resident altercations identified. Nursing staff retraining was held on June 20, 2018 by the DON on the requirement to report all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property and the results of all the investigations of alleged violations to the administrator and other officials in accordance with state law. All alleged violations will be reported immediately but no later than 2 hours-if the alleged violation involves abuse or results in serious injury; or 24 hours-if the alleged violation does not involve abuse and does not result in serious bodily injury. Staff training included the definition	

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F 609	Continued From page 9 notified and DON [director of nursing] notified at this time. Further review of R24's medical record revealed no further investigation had been completed related to the incident. #2: PN dated 12/21/17, 8:05 p.m. indicated R24 pushed a female resident in her wheelchair around the unit. The female resident kept asking him to stop and to leave her alone yet R24 continued to push her. Staff redirected R24 multiple times and he continued to go back to her and push her around. The progress note indicated staff had been in the medication room when R24 was heard to yell "I'm gonna kill you!" Staff ran to the dining area where R24 was seen with his hands around the female resident's throat trying to choke her. As staff separated the residents, R24 stated "you all are animals, gonna kill all of you!" Subsequent PN's related to this altercation revealed the following: --PN dated 12/22/17, 9:17 a.m. indicated the social worker was alerted to all the facts from last night and the DON would be called for a solution. --PN dated 12/22/17, 11:21 a.m. indicated upon review of the incident, there was no injury, pain or mental anguish present. Staff had been able to redirect R24 without incident and it was resolved. --PN dated 12/22/17, 12:49 p.m. indicated report to SA was not warranted for this incident. #3: PN dated 5/15/18, indicated staff had been in the dining room doing 1:1 with another resident, when someone was heard to holler "Ouch. Help!" R24 was observed ramming R23 into the sofa, and a skin tear was noted to the top of P23's left hand. R24 had not comprehended he hurt R23, and had not been willing to understand. R24's wife was informed of the incident. Further review	F 609	of willful as it pertains to resident to resident altercations. Willful means the individuals action was deliberate (not inadvertent or accidental) regardless of whether the individual intended to inflict injury or harm. Risk management reports involving resident to resident altercations will be audited for reporting compliance by the DON, NOC charge nurse or designee for 2/24 hour reporting and persons notified. 7x week x 1month/ 2x week x 2 week/ 1x week x 1 week. The audits will be reviewed by the IDT during the morning meeting held Mon-Fri for any patterns, trends,lack of compliance or further staff training needs. The DON, or designee will ensure compliance. Results of the audits will be reported to QAPI committee.	

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F 609	Continued From page 10	F 609		

of R24's medical record revealed no further investigation had been completed related to the incident.

#4: PN dated 5/19/18, indicated R24 had been spinning R23 around in circles in her wheelchair against her wishes. R23 had hollered out for help and stated "He's hurting me." R24's hand were not observed on R24, but on the arms of the wheelchair. R24 had an angry expression and stated angrily "She doesn't listen!" R24 had been separated from R23 and asked to sit down on the couch for a while. R23 was removed from the area so R24 would not attempt to push her wheelchair around again. After R23 was removed, R24 was pushing a male resident around. Behavior was difficult to redirect and reoccurred. Intensity of behavior was an eight when occurred. Further review of R24's medical record revealed no further investigation had been completed related to the incident.

On 5/23/18, at 11:52 a.m. the licensed social worker (LSW) indicated the facility abuse policy had recently been revised and resident to resident abuse had been incorporated into the general abuse principles within the policy. LSW stated the facility staff utilized an algorithm which was posted at each nurses' station to determine when a resident to resident altercation was willful and required reporting to the SA. LSW stated willful meant the resident had an understanding of what they were doing and they intended it to happen. If the action wasn't willful or the resident didn't have an understanding of what they were doing, the expectation would be for staff to put a note in the electronic record and protect the residents involved.

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On 5/24/18, at 9:28 a.m. registered nurse (RN)-A confirmed she used the algorithm to determine when a resident to resident altercation required reporting to the SA based on the resident's intent. After review of the State Operations Manual (SOM) definition of willful as used in the definition of abuse, RN-A stated the aforementioned incidents should have been reported to the SA.

On 5/24/18, at 1:40 p.m. the director of nursing (DON) confirmed the aforementioned incidents of resident to resident abuse should have been reported to the SA, as required.

R33's PN dated 4/8/18, at 6:45 a.m. indicated at 10:45 p.m. R33's roommate (R46) was observed holding onto R33's arm and forcing R33 out of their room. R46 was about to push R33 backwards however, an unidentified NA intervened before further physical aggression could occur. R33 "appeared afraid." R33 was removed from the area. The staff member placed a call to the administrator and DON and informed them of the incident. R33 had not sustained an injury.

R33's PN dated 5/1/18, at 9:22 p.m. indicated R33 was observed striking R30 in the forehead with a closed fist. R30 did not sustain injury. When questioned about the incident R33 stated "it was an incident." No further documentation was noted in the record regarding the incident.

The facility Vulnerable Adult reports were reviewed from 11/1/17, to 5/22/18. No reports were available related to the two aforementioned incidents.

On 5/23/18, at 8:50 a.m. NA-A stated if she

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witnessed residents' hitting at each other, she would separate them and report the incident to the nurse. NA-A stated R33 occasionally required one to one supervision to ensure R33 did not have altercations with others.
-At 9:19 a.m. RN-A reviewed R33's PN's from 4/8/18, and 5/1/18. RN-A stated she was unaware of the two incidents noted in the PN's and would have to look into them.
-At 10:32 a.m. RN-A stated she had reviewed R33's clinical record and confirmed the incidents had not been reported to the SA. In addition, RN-A stated the incident on 5/1/18, had also not been reported to the administrator or the DON. RN-A stated the facility utilized an algorithm to determine if the incidents were reportable or not and the charge nurse working at the time of the incident was to determine if the incident was reportable and to report if the resident who had started the altercation was willful in their actions. RN-A stated the incidents should have been reported.
-At 11:24 a.m. the LSW stated the facility Abuse policy was up to date and the staff were to use an algorithm in order to determine if the incidents were to be reported to the SA or not.
The Resident to Resident Altercations algorithm dated 4/2013, indicated "willful means that the individual intended the actions itself that he/she knew or should have known could cause physical harm, pain or mental anguish. Even thought a resident may have a cognitive impairment, he/she could still commit a willful act." The algorithm directed the reader to determine if the direct actions resulted in the infliction of injury, unreasonable confinement, intimidation or physical with resulting physical harm, pain or mental anguish. If the resident did not receive physical harm, pain or mental anguish, the

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F 609	Continued From page 13 incident was not to be considered reportable to the SA. However, this algorithm utilized by the facility was out dated as did not include the new Centers for Medicare Services (CMS) regulations which directs that all alleged violations involving abuse are reported immediately, but not later than 2 hours. On 5/23/18, at 3:05 p.m. RN-C stated all of the staff were to determine if the incidents were willful or not. RN-C stated she was unaware the algorithm was out of date and that residents with dementia did have the ability to willfully abuse others even if they were not cognitively intact. Upon review of R33's incidents, RN-C confirmed the incidents should have been reported to the SA. The Resident Protection Program Policy date stamped as reviewed by the facility on 3/5/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm pain or mental anguish. Willful means the individual must have acted deliberately. The employees must always report abuse immediately to the administrator who in turn would involve the DON. The Abuse, Mistreatment and Misappropriation of Resident Property Reporting policy and procedure effective 11/28/16, indicated an incident of abuse, neglect, mistreatment and misappropriation of property would immediately report this incident or suspected incident to the administrator and to the SA per State and Federal requirements.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		6/29/18

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F 610	Continued From page 14 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 incidents of potential resident to resident abuse had been thoroughly investigated for 3 of 3 residents (R300, R24, R23) who resided on the secured unit and had been involved in resident to resident altercations. Findings include: Review of R24's Progress Notes (PN) from 11/9/17, to 5/22/18, revealed the following resident to resident altercations: #1: PN dated 11/9/17, 10:57 p.m. indicated on 11/9/18, a nursing assistant (NA) reported he had heard hollering, went to check and had found R24 leaving his room with blood on his right shirt sleeve and R300 hollering at R24 with a comb in	F 610	The SOM was reviewed for guidance regarding evidence that all alleged violations are thoroughly investigated. Prevent further abuse, neglect, exploitation, or mistreatment while the investigation is in progress, and report the results to the administrator and other state officials in accordance with the law, including the State Survey Agency, within 5 working days. The facility identified that any resident involved in alleged abusive situations or incidents has the potential to be affected. Facility corrective action included retraining the nursing staff on June 20, 2018 by the DON on the requirement to report all alleged violations of abuse,	

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F 610	Continued From page 15 his hand. R24 presented with a skin tear on the right arm measuring 5.0 centimeters (cm) x 3.0 cm, irregular in shape. The progress note indicated R24 tended to hover over other residents trying to be of help to them which startled other residents causing them to lash out in anger. R300 was a resident who startled easily. Charge RN [registered nurse] notified, Unit coordinator notified and DON [director of nursing] notified at this time. Further review of R24's medical record revealed no further investigation had been completed related to the incident. #2: PN dated 5/15/18, indicated staff had been in the dining room doing 1:1 with another resident, when someone was heard to holler "Ouch. Help!" R24 was observed ramming R23 into the sofa, and a skin tear was noted to the top of P23's left hand. R24 had not comprehended he hurt R23, and had not been willing to understand. R24's wife was informed of the incident. Further review of R24's medical record revealed no further investigation had been completed related to the incident. #3: PN dated 5/19/18, indicated R24 had been spinning R23 around in circles in her wheelchair against her wishes. R23 had hollered out for help and stated "He's hurting me." R24's hand were not observed on R24, but on the arms of the wheelchair. R24 had an angry expression and stated angrily "She doesn't listen!" R24 had been separated from R23 and asked to sit down on the couch for awhile. R23 was removed from the area so R24 would not attempt to push her wheelchair around again. After R23 was removed, R24 was pushing a male resident around. Behavior was difficult to redirect and reoccurred. Intensity of behavior was an 8 when	F 610	neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property and the results of all the investigations of alleged violations to the administrator and other officials in accordance with state law. Staff training will include training on PMCC's Resident Protection Program policy and completing the investigation forms which may include root cause analysis, interviews, chart reviews, or observations. Staff training will include how to maintain the documentation, prevent further potential abuse, neglect, exploitation, or mistreatment during the investigation, and how to follow up after an investigation if the allegation is verified. Risk management reports involving resident to resident altercations will be audited for investigation compliance by the DON, NOC charge nurse, or designee 7x week x 1month/ 2x week x 2 week/ 1x week x 1 week. The audits will be reviewed for trends, completion, compliance, and for any need for staff training or re-education by the IDT Mon-Fri during the morning meeting. The DON, or designee will ensure compliance. Audit reports will be reviewed at QAPI	

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occurred. Further review of R24's medical record revealed no further investigation had been completed related to the incident.

The facility Vulnerable Adult reports were reviewed from 11/1/17, to 5/22/18. No reports/investigations were available related to the aforementioned incidents.

On 5/23/18, at 11:52 a.m. the licensed social worker (LSW) indicated the facility abuse policy had recently been revised and resident to resident abuse had been incorporated into the general abuse principles within the policy. LSW also indicated the facility staff utilized an algorithm which was posted at each nurses' station. LSW indicated her expectation was the algorithm helped staff to determine if an action was willful and required an investigation. LSW indicated willful meant the resident had an understanding of what they were doing and they intended it to happen. LSW indicated if the action wasn't willful or the resident didn't have an understanding of what they were doing, the expectation would be for staff to put a note in the electronic record and protect the residents involved.

On 5/24/18, at 9:28 a.m. registered nurse (RN)-A confirmed the aforementioned incidents had not been investigated but should have been.

On 5/24/18, at 1:40 p.m. the director of nursing confirmed the aforementioned incidents of resident to resident abuse should have been investigated, as required.

The Resident Protection Program policy dated 3/5/18, indicated the nurse would begin the

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F 610	Continued From page 17 investigation immediately and a root cause investigation and analysis would be completed. The policy indicated the investigation would include: who was involved, resident's statements, resident's roommate statements (if applicable), involved staff and witness statement of events, a description of the resident's behavior and environment at the time of the incident, injuries present, observation of resident and staff behaviors during investigation and environmental considerations.	F 610		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services as directed in order to prevent the decline in ambulation abilities of 1 of 1 resident	F 688	The SOM was reviewed for guidance regarding mobility and nursing interventions to ensure that a resident who enters the facility without limited	6/29/18

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F 688	Continued From page 18 (R15) observed to have declined in the ability to ambulate. The lack of the provision of ambulation services resulted in actual harm for R15 as evidenced by her inability to ambulate. In addition, the facility failed to monitor range of motion (ROM) services for 1 of 1 resident (R4) who had identified ROM limitations in the left thumb and had sustained a decrease in ROM resulting in actual harm. Findings include: R15's admission Minimum Data Set (MDS) dated 3/8/18, indicated R15 had diagnoses including dementia and Parkinson's disease. The MDS indicated R15 had severe cognitive impairment and required extensive assist of one staff for all activities of daily living. The MDS indicated R15 had no impairments in range of motion (ROM) of the lower extremities and was able to transfer/ambulate with assist of one person. R15's Activities of Daily Living Care Area Assessment (CAA) dated 3/12/18, indicated R15 was ambulatory and required hand held assistance of one staff with all ambulation and transfers. R15's Physical Therapy Discharge Summary dated 3/26/18, indicated R15 was able to transfer/ambulate (100-200 feet) with stand-by to minimal assistance of one staff. Functional limitation for mobility was at least 20% but less than 40% impaired/limited or restricted. Recommendations to transfer/ambulate R15 with assist of one and front wheeled walker. Prognosis was good with consistent staff follow-through.	F 688	ROM does not experience a reduction in ROM, to ensure a resident with limited ROM receives appropriate treatment, services, equipment and assistance to maintain or improve mobility unless a reduction in mobility is unavoidable. All resident's with a functional restorative maintenance plan has the ability to be affected. Facility corrective action will include re-education of the nursing staff on June 20th, 2018 by the DON. Education will consist of how to report to therapy if a resident is noted to have sustained a decline, Review of Passive and Active ROM. The assessments for ROM, Mobility, identifying resident's current movement and ROM and whether the resident has maintained, declined, or why the functional restorative maintenance plan was stopped. Nursing staff will review the restorative programs on a monthly basis to ensure any decline is identified and services are being provided, and make the appropriate referrals to PT/OT if warranted. Resident R15 was assessed for Activities for Daily Living and the care plan updated to reflect the current status. The Doctor had been notified regarding the decline and ordered therapy for conditioning. R15 was evaluated by PT/OT and is receiving therapy services. Resident R4 was assessed by nursing, care plan updated as needed, and per the facility policy was directed to therapy due	

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F 688	Continued From page 19 R15's progress notes (PN) were reviewed from 3/6/18, to present which revealed a lack of documentation related to R15's progressive decline in ambulation ability. A PN dated 5/17/18, indicated at 7:36 p.m. the doctor was updated about R15 being unable to ambulate and having difficulty with transfers. R15's Order Summary Report revealed an order for physical therapy for conditioning - fall risk. R15's care plan provided on 5/22/18, directed two staff to ambulate with front wheeled walker, a gaitbelt, and the wheelchair to follow two to three times per week for 50-100 feet. R15 required limited to extensive assistance of one staff to transfer with hand held assistance. On 5/22/18, at 7:29 a.m. nursing assistant (NA)-E and registered nurse (RN)-D were observed to assist R15 to transfer from bed to the chair. A transfer belt was applied and NA-E and RN-D attempted to stand R15, however, due to R15's observed inability to stand, staff proceeded to lift R15 by gait belt and the back of her slacks. R15's feet were lifted off the ground and did not touch the floor as she was placed into the wheelchair. -At 7:35 a.m. NA-E stated R15's ability to stand and transfer was getting worse and that R15 did not walk any more. NA-E confirmed R15 was on a restorative ambulation program but staff only implemented the program when they had time. -At 2:30 p.m. RN-D confirmed R15 had been declining in ambulation and had a referral for physical therapy dated 5/17/18, to evaluate because at present, R15 required total lift by staff to transfer and was no longer able to ambulate. RN-D confirmed R15 had a restorative program	F 688	to a noted decline in ROM. Therapy did an evaluation and has been working with R4. Any resident declines noted by nursing will be discussed during the morning IDT meeting as well as during the weekly meeting with OT/PT. All residents will have a Range of motion assessment completed on admission, quarterly and with a significant change. Any staff members noted to be non-compliant with following the ROM care plan will be re-educated and or receive corrective actions by the DON or designee. Random ROM audits will be completed by the DON or Designee 3x week x 1month/ 2x week x 2 week/ 1x week x 1 week. The DON, or designee will ensure compliance. Audits will be reviewed during QAPI.	

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and stated some days, providing the services was a challenge to get the restorative tasks completed. RN-D could not recall the last time R15 had ambulated. RN-D also confirmed even though R15 had received a physical therapy evaluation order written on 5/17/18, she had not yet been evaluated..

On 5/23/18, at 8:45 a.m. NA-E and NA-G were observed in R15's room with a hoyer lift (full body mechanical lift). Staff stated they were given the directive to use the lift to transfer R15. During preparation to use the lift, NA-G realized that R15's bed could not be raised high enough for the lift to go underneath the bed therefore, a gait belt was applied to R15 and NA-E and NA-G proceeded to lift R15 and physically place her in the wheelchair. R15 was unable to stand. At 8:50 a.m. NA-G could not recall the last time R15 was able to ambulate

Review of R15's daily task documentation for ambulation revealed the services had not been provided as directed. In addition, the documentation noted a decline in R15's ambulation ability from March 2018, through May 2018.

R15's progress note dated 5/22/18, indicated R15 had had a decline in functioning, difficulty transferring, not able to bear weight, or able to ambulate. The note indicated R15 would be transferred via hoyer lift until further direction received per physical therapy.

Physical Therapy Evaluation completed on 5/23/18, indicated R15 demonstrated functional decline as well as decreased lower extremity ROM and pronounced tone affecting positioning

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and mobility. Functional limitations for mobility were at 100% impaired, limited or restricted. R15 was unable to stand or ambulate during assessment.

On 5/24/18, at 9:48 a.m. the physical therapy assistant (PTA) stated R15 was getting tighter with seating position and was evaluated yesterday and a decline was noted. When questioned about the evaluation form's documentation coding, the PTA stated the physical therapist was out of the building and that the occupational therapist would be able to explain the evaluation documentation.

On 5/24/18, at 10:28 a.m. occupational therapist (OT)-A stated the therapy departments were alerted of a change in a resident's condition by the nurses or when they received a referral for therapy. Although R15's physician order for physical therapy referral was received on 5/17/18, OT-A confirmed the referral was not received by physical therapy until 5/22/18, in which R15 was evaluated on 5/23/8. OT-A reviewed the evaluation coding documentation and confirmed R15's evaluation indicated R15 had a 100% impairment related to mobility.

-At 10:41 a.m. RN-D stated R15's decline with transfers and ambulation was brought to her attention just last week. RN-D stated when an order was received, a consult form was completed by staff and sent to therapy that same day, however, RN-D could not recall when R15's order for therapy was completed and sent to therapy. When asked to review the consult referral, RN-D stated she could not locate it. Although R15 had a progressive decline in ambulation ability, her clinical record lacked a

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reassessment related to causal factors. In addition, R15's rehab program was not reviewed in order to identify the lack of the provision of services.

R4's quarterly MDS dated 5/17/18, indicated R4 had diagnoses including dementia and hemiplegia (weakness of one entire side of the body). The MDS indicated R4 required extensive assistance with all activities of daily living and he displayed functional limitations in ROM on one side.

R4's Activities of Daily Living CAA dated 2/15/18, indicated R4 had left sided hemiplegia following a stroke and required assistance of staff for activities of daily living.

R4's care plan provided on 5/24/18, indicated R4 had left sided hemiplegia and directed the staff to ensure R4 wore a resting hand splint at all times and to provide passive range of motion (PROM) to the upper and lower extremities. The goal was to ensure R4 was able to maintain mobility without evidence of a new contracture.

On 5/20/18, at 2:30 p.m. R4 was observed in the dining room, seated in a wheelchair with a resting splint on the left hand. The left hand fingers were positioned in an extended position, however, the left thumb was curled under the splint.

On 5/22/18, at 8:35 a.m. NA-D and NA-B were observed to assist R4 with morning cares. R4 was wearing the splint on his left hand. The thumb continued to be curled under the splint between the splint and R4's palm. During the cares, NA-D and NA-B were not observed to

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remove the splint or provide PROM exercises to the hand. At 8:53 a.m. NA-B stated PROM services would be provided after breakfast.

On 5/23/18, at 9:55 a.m. NA-A and NA-C were observed to assist R4 to bed via a full body mechanical lift. Once in bed, the NAs performed PROM exercises for R4. NA-A removed R4's splint from his hand. NA-A was able to extend R4's fingers approximately half way open and provide PROM to the fingers, however, R4's thumb remained in a fixed, inward curled position towards the palm. The first thumb was joint bent at a 90 degree angle. NA-A was able to place one of her fingers between the thumb and the palm of R4's hand but stated the thumb was unable to be moved further. NA-A stated R4's finger mobility had not changed but the thumb was tighter, more fixed.

-At 10:06 a.m. NA-C stated she had identified R4's thumb was not moving as well as it had in the past and had reported the concern to licensed practical nurse (LPN)-A.

-At 10:30 a.m. LPN-A stated she could not recall any concerns being reported to her regarding R4's thumb ROM.

Review of R4's Documentation Survey Report v2, dated 3/18, 4/18 and 5/18, indicated R4 received PROM exercises five to seven days a week.

Review of R4's clinical record lacked documentation related to R4's ROM program.

-At 2:55 p.m. RN-C was observed to complete PROM for R4's left thumb. RN-C attempted to move the thumb, however, it was not opposable

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F 688	Continued From page 24 (capable of moving toward and touching the other digits on the same hand). The thumb was able to move less than one centimeter back and forth and the first joint was noted to be contracted in a fixed 90 degree angled position. RN-C confirmed R4's thumb had sustained a decrease in mobility and was no longer opposable and the first joint was contracted. Upon review of R4's clinical record, RN-C stated the facility ensured the PROM services were provided and documented as directed, however, the facility did not have a system in place to supervise/review the ROM services provided in order to determine if changes had occurred in the resident's ROM status. RN-C stated the nursing assistants who provided the ROM services would be the most knowledgeable if the ROM had decreased. The PT/OT/Rehab Nursing policy dated 5/23/18, directed the nursing staff to review the restorative programs on a quarterly basis. The policy also directed the staff to report to therapy if a resident was noted to have sustained a decline.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate	F 689	A comprehensive assessment review was completed on 5/22/2018. The findings are	6/29/18

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F 689	Continued From page 25 causal factors of falls, and failed to ensure adequate supervision and interventions were implemented in order to minimize falls and/or injury for 1 of 1 resident (R113) who sustained multiple falls resulting in injury including two fractures. This deficient practice resulted in an immediate jeopardy (IJ) with the potential risk of serious harm, injury or death. The immediate jeopardy began on 4/1/18, when R113 first hit her head during a fall and the facility failed to conduct an assessment of factors contributing to R113's falls and failed to determine and implement effective interventions to reduce falls to prevent serious injury or death. The IJ was identified on 5/22/18, and the administrator and director of nursing (DON) were notified on 5/22/18, at 2:22 p.m. The IJ was removed on 5/23/18, but non noncompliance remained at the lower scope and severity level of G - isolated, which indicated actual harm that is not immediate jeopardy. Findings include: R113's admission Minimum Data Set (MDS) dated 3/28/18, indicated R113 had diagnoses including Alzheimer's dementia and anxiety disorder. The MDS also indicated R113 had severely impaired cognition, a history of falls, was independent in bed mobility, and required supervision with transfers and ambulation. R113's care plan revealed a written entry dated 5/17/18, staff assistance required due to non weight bearing status due to a right hip fracture with surgical repair. R113's Falls Care Area Assessment (CAA) dated 3/28/18, indicated R113 had sustained falls prior to admission. R113 had been observed to have	F 689	as follows: Physical Therapy note review: Note from 5/11/2018-Transfer training was held with R113 and RN. Work on sit to stand and SPT with FWW, heavy encouragement and facilitation (verbal, visual, and tactile) for TTWB R LE including placing foot forward with sit<>stand as well as and working on toe touch WB with pivot. Resident unable to follow TTWB with verbal cues or placement of therapist foot under resident heel. Resident able to "tip toe" which produces a step to pattern to offload R LE. OT notes report Provided training with w/c mobility with adequate follow through. R113 requires MIA/MOA for dynamic stand balance as well as FWW. Therapy note sent to Altru for return appointment on 5/23/2018 reports resident is unable to recall TTWB status and compliance is poor. PT/OT working on strength, balance, and mobility. Therapy inquiring as to the possibility of proceeding to WBAT as soon as able, Dr. to advise. Resident R113 has had 3 recent falls with the last fall occurring on 5/8/2018. The following UDA's were completed and reviewed on 5/22/2018: by the IDT staff consisting of the unit coordinators, DON, MDS, SS, and Administrator to assist with the creation of the comprehensive falls assessment. Resident has a history of	

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F 689	Continued From page 26 episodes of constant pacing and fatigue which increased her risk for falls. R113 required placement on the locked special care unit due to the pacing and exit seeking behaviors. R113's Fall Risk Assessment dated 3/22/18, indicated R113 was at high risk for falls. R113's care plan received on 5/21/18, indicated R113 was at risk of falls due to the constant pacing which resulted in fatigue. At times, R113 had an unsteady gait and balance and was unable to correct herself when unsteady. R113 required the special care unit due to pacing and exit seeking behaviors. R113 had poor safety awareness. The plan directed the staff to monitor R113, encourage R113 to participate in activities and to rest when tired. On 5/11/18, the care plan was updated to include R113's new non-ambulatory status following a right hip fracture. R113 was limited to toe touch weight bearing only and had been identified as being non complaint with the weight bearing directive. The plan directed the staff to remind R113 of the toe touch weight bearing status. On 5/20/18, at 1:40 p.m. family member (FM)-A stated R113 had sustained two falls in the facility which resulted in a fractured wrist and a week later a fractured hip. -At 4:48 p.m. R113 was observed seated in a wheelchair with a right wrist splint on and independently wheeling throughout the special care unit. R113 stopped in the hallway by her room door, stood up applying full weight to both lower extremities and took a step forward. No staff members were in view of R113. The State agency (SA) staff positioned herself in front of R113 in order to prevent a potential fall, and began talking to R113. At that time, nursing assistant (NA)-A exited another resident room, approached R113 and directed R113 to sit in the	F 689	anxiety, Alzheimer's disease, Generalized anxiety disorder, OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE, UNSPECIFIED SIT Falls Tool for identifying risk factors: Risk factors; evaluated on 5/22/2018 by the unit managers, MDS coordinator, DON, SSD, were: Resident R113 history of falls prior to admission as noted at the time of admission by R113s family, Recent falls, Medication, cognitive status, and automatic high risk status for falls. Restlessness due to wandering and looking for her husband(who the resident is unaware by the family choice, is deceased.) Findings on 5/22/2018 are as follows: History of 3 or more falls in the past 3 months while a resident, Medication review: Takes 1-2 of the high risk medications (Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics) Resident did have recent surgery on her hip and admitted on Citralopram for anxiety. Ativan was discontinued on 3/28-18. Medication changes on 5/22/2018 were scheduled Tylenol for pain rather than PRN. Resident wandering/restlessness may be due to R113 not being able to vocalize her pain	

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F 689	Continued From page 27 wheelchair. NA-A stated to R113, "Remember, you have a broken hip. You can not walk." -At 4:50 p.m. R113 was alone in her room, seated in a recliner. R113 was not within view of any staff members. -At 5:10 p.m. R113 was seated in a wheelchair in the dining room eating the evening meal. -At 7:15 p.m. R113 was independently walking in the hallway without any type of assistive devices. R113's gait was steady with a slight limp on the right side. The SA staff alerted registered nurse (RN)-A of R113's self ambulation. RN-A immediately approached R113 and directed R113 to sit down in the living room recliner. RN-A reminded R113 that she was not able to walk due to her broken hip. R113 had walked approximately 20-30 feet without the staff interventions. -At 7:17 p.m. R113 was seated in a recliner in the lobby asking other residents, visitors, and staff for her deceased husband. NA-A informed R113 her husband would be back in the morning and she was to relax in the chair. R113 remained in the recliner. On 5/21/18, at 9:00 a.m. R113 was observed alone in her room seated in a recliner with no staff members within sight of her. -At 10:00 a.m. R113 remained in her room, seated in the recliner. Review of R113's Progress Notes and corresponding Incident Reports revealed the following: 1. 4/1/18, at 7:30 p.m. R113 had been pacing with shoes and a coat on. She was carrying her purse and searching for a way to go home. Moments later, R113 was found on the floor laying on her stomach, with her feet stretched out and blood coming from her. R113 was noted to have a 3.0 cm (centimeter) bruise/bump on her	F 689	and make her needs know. Charting will include effectiveness of the pain medication. Consulting Pharmacist conducted a chart review of medications on 5/23/2018. As of 2:56 pm on 5/23/2018 the Pharmacy consultant suggestions include: " 1.Consider reducing citalopram to help rule out contributing to falls " consider trying routine APAP to help manage anxiety not relieved by citalopram and manage pain " Consider reassessing whether R113 needs to continue on ranitidine as it may contribute to confusion. These recommendations will be faxed to the medical provider immediately and await his follow up. Any changes by the MD will be immediately implemented and chart updated by unit coordinator /DON or designee. Medical provider was in facility today and reviewed resident's weights, vitals and orders. He did not see resident d/t she was at another appointment. He did goven new orders for Tylenol 1000 mg po TID and to decrease Celexa to 10 mg po daily. MD stated will trial this and then consider adding low dose of remeron if continued anxiety/ wanting to find husband. MAR, pharmacy and family updated. Psychological findings on 5/22/2018 showed minimally affected by depression with a PHQ of 2. Resident R113 cognitive status performed on 5/17/2018 showed severe impairment. This indicates the resident cannot be educated on safety concerns, but instead needs cuing or	

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F 689	Continued From page 28 forehead, a "slit" across the bridge of her nose and a slit in the right nostril. Blood was noted from her nose and the slits. R113 complained of pain in her head. The physican was notified and R113 was sent to the emergency room for an evaluation. R113 received a MRI while at the hospital and returned to the facility. The family was contacted and encouraged the facility to utilize essential oils for calming such as lavender and frankincense. R113's care plan was updated to use the oils. R133's head scan results dated 4/1/18, indicated R113 had not sustained an internal skull injury at the time of the fall. 2. 4/18/18, at 3:45 p.m. R113 was found attempting to assist herself off of the main living room floor. R113 was noted to have a 1.0 cm x 1.0 cm scrape on the right side of her cheek. R113 stated she was trying to assist another resident when she fell. RN-A reviewed the fall on 4/18/18, and indicated R113 had been attempting to assist R23 to stand when she fell. R113 had been wandering and looking for her husband. The care plan was updated to encourage R113 to participate in group activities in the afternoon. 3. 4/18/18, at 9:57 p.m. R113 fell in her room as an unidentified NA walked by the room. R113 sustained two abrasions to the left upper forearm. The first measured 3.5 cm x 0.5 cm and the second measured 1.0 cm x 0.5 cm. R113 did not complain of pain with the fall. RN-A reviewed the fall and indicated R113 was tired and unsteady due to pacing, the care plan had been followed and the staff were to encourage R113 to lay down when tired. No further interventions were put into place. 4. 5/1/18, at 12:35 a.m. R113 was heard by staff members hollering out in her room. Upon entering the room, R113 was found sitting in an	F 689	reminders for implementing interventions. This will be the active therapeutic approach used by staff and sitters. Clinical mobility assessment showed the resident has extremely impaired mobility. Resident currently spends most of her time in a wheelchair and due to hip is on non weight bearing as of 5/11/2018. Chart notes report that due to cognition resident is non-compliant with toe touch weight bearing. Wandering Assessment: Resident is at high risk for wandering due to her history, disorientation fear, anxiety, and Alzheimer's disease. R113 is a current resident in a SU. Altru, Grand Forks, ND where R113 had her surgery is aware of non-compliance. Staff will continue to remind and cue resident as to her mobility limitations. Resident has been noted to attempt self ambulation and to self-transfer by care center staff as well as therapy documentation. Due to this continued risk to the resident a sitter has been put in place 24 hours a day. Re-evaluation of needs will be completed after R113 returns from a follow up appointment with her surgeon/physician at Altru Grand Forks today, 5/23/2018. Risk factor checklist and Intervention plan: Clinical mobility assessment done on 5/22/2018 showed Mobility/transfer-observed impulsive-risk taking behavior. 1-1 sitter will assure conform to mobility as doctor directed.	

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F 689	Continued From page 29 upright position in the middle of her room. R113 was unable to recall what happened. R113 stated, "Ow" when the right shoulder and wrist were touched. No displacement was noted. R113 was assisted back to bed and encouraged to rest. Subsequent PNs revealed: -5:40 a.m. R113 slept well through the night. -At 6:07 a.m. R113 complained of right wrist pain. The wrist was noted to be swollen and discolored. -At 9:58 a.m. RN-A reviewed the clinical record and noted that R113's right wrist and hand were bruised. R113 was not flexing the hand or moving the fingers by self. When the staff moved the fingers, R113 flinched and complained in pain. R113 was given an ice pack and Tylenol for discomfort. R113's physican was notified of the fall and stated he would see R113 on 5/2/18, during rounds. -5/2/18, R113 was seen by the physician and an x-ray of the right wrist was ordered. No treatment orders were written. However, due to scheduling difficulties, R113 did not have the x-ray until 5/4/18. -5/4/18, R113's x-ray report dated 5/4/18, indicated R4 had a nondisplaced transverse fracture of the distal right radius (wrist fracture). R113 received a wrist splint to wear. 5. 5/7/18, at 10:40 p.m. a loud sound was heard from the living room. R113 was found on the floor next to the couch on her right side. R113 was noted to have a 0.2 x 0.2 cm abrasion on the right elbow. R113 did not complain of pain, however, upon assisting to a standing position, R113 was unable to bear weight on the right leg. R113 was transferred to the local hospital and was diagnosed with a fractured hip. R113 was then	F 689	Mental statues BIMs and PHQ-9 conducted on 5/17/2018 showed Cognitive -restlessness, impulsive, and difficulty following instructions with mild depression. Diversion activities will be used to address restlessness and calls made to her husband as R113 requests. Immediate action plan: is to provide 1-1 sitter 24 hours a day beginning 5/22/2018 and Random audits to be performed to ensure compliance two times per shift by the staff nurse on Valley or Evergreen or Oak as assigned by DON, unit coordinators, or designee. Staff to staff verbal reports/education will occur during each shift change to update on any care plan updates or modifications. Direct staff NARs, will along with verbal updates will be provided with updated care plan sheets/ADL sheets. The ADL sheets will be updated at anytime there are changes or modifications made to R113 care plan. Care plans will be updated to changes by the unit coordinator, DON or Designee. Bladder/Bowel assessment was started evening of 5/22/2018. It is currently being conducted by the 24 hour sitter and findings will be reviewed at the completion of 72 hours by the DON/ unit coordinator or designee and updates immediately implemented if needed. When family or non-staff are sitting wthR113 they will put the call light on to have staff assist R113 to the bathroom and address her needs. The facility staff are also responsible to document on activities and B/B and sleep	

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F 689	Continued From page 30 transferred to a larger hospital for surgical repair of the fractured hip. R113 returned to the facility on 5/11/18. Upon review of the surveillance video, R113 was noted to be standing next to the couch and trying to maintain her balance without putting weight on her right leg. The facilty indicated the fracture was possibly the result of a pathological fracture therefore, it was not necessary to modify R113's care plan or facility policies and procedures. -R113's Hospital Discharge Summary dated 5/11/18, indicated R113 had sustained a right hip (femoral) fracture with the placement of three screws across the right femoral neck fracture. The discharge summary indicated R113 was to be on toe touch weight bearing status. 6. 5/15/18, at 10:56 p.m. the staff heard a loud noise in the dining room. R113 was found on the floor with an unidentified skin tear on her left front lower leg. The area was washed and a 2 x 2 dressing was applied. The care plan was updated to ensure R113 was within the staff sight during shift report. On 5/21/18, at 9:58 a.m. licensed practical nurse (LPN)-A stated it was hard to prevent resident falls or monitor R113 because the facility had several residents that were at risk for falls. LPN-A stated the staff monitored resident rooms by looking in each door when they were walking down the hallways and other than that, the staff did not have any type of formal monitoring system for R113. LPN-A stated staff would remind R113 to use the call light and ask for assistance. -At 10:00 a.m. NA-A stated R113 did not remember that she was unable to ambulate on her own or that she had a broken hip and was not	F 689	study. Family volunteers are only used as a sitter. As of 5/22/2018 Bowel/Bladder assessment staff to offer prompt toilet when awake and about 3-4 hours and PRN. Resident is incontinent of bladder at times and wears a pull up. The toileting assessment will trigger follow-up documentation after 72 hours. An activity log of likes/dislikes was started on 5/22/2018 and will be maintained during the course of 1-1s. A sleep study, begin date of 5/22/2018 and will be documented for 72 hours to note patterns of wake/sleep and restlessness. Follow up will be evaluated at the completion by the unit coordinator and DON with new care plan interventions implemented if warranted. Activity data Interest Assessment: Interviews with the family were conducted on admission and again on 5/22/2018. Resident liked to travel, have coffee and socialize with her friends. Past interests also included cooking, doing ceramics and gardening. Divisional Intervention to try include: Trialed folding and sorting activity was attempted on 5/21/2018 but R113 was not interested and DC. After review of Activity interview from admission 3/28/2018 and phone interview with family on 5/22/2018, Staff will encourage R113 to participate in planned afternoon activities.	

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F 689	Continued From page 31 to bear weight/walk on it. NA-A stated R113 continued to attempt to walk on her own and did not have any type of special individualized fall interventions in place. NA-A stated R113's pacing behaviors increased in the evening. -At 2:00 p.m. trained medication assistant (TMA)-A stated R113 enjoyed sitting in her room watching crime based television mystery shows. TMA-A stated R113 preferred to stay in her room however, did not like to be seated for very long. TMA-A stated other than having R113 stay in the common areas as much as possible, there were no special, individualized interventions in place for R113. TMA-A could not recall any type of special or increased monitoring for R113. -At 2:10 p.m. NA-B stated the staff monitored the residents by walking down the hallway and looking into their rooms. NA-B stated R113 was to wear gripper socks and the staff were to check on her, as able. -At 2:04 p.m. RN-B stated she routinely worked the evening and night shifts on the special care unit. RN-B confirmed R113 had a very short memory and stated she did not express pain, therefore, continued to attempt to ambulate bearing full weight on the fractured hip. RN-B stated R113 was to utilize gripper socks at all times, however, R113's feet would become warm so she would remove the socks on her own. RN-B also stated R113 required constant reminders as she repeatedly attempted to self transfer and ambulate without assistance. RN-B stated R113 required supervision and the interdisciplinary team would be meeting later that day (5/21/18) to review R113's falls. -At 2:46 p.m. RN-A stated the staff on duty at the time of each resident fall were to review the fall and determine the root cause. The RN unit manager or house manager would then review	F 689	If restless help R113 to use phone at her request to try and call her husband-do not orient her to the fact he has passed per her family. Remove from table when done with meals but offer coffee as family report she liked to watch TV and drink coffee. R113 Chair was removed on Thursday, 5-17-18 and recliner place in room that foot rest go up/down. Present status: Activity log 5/22/2018 is placed with sitter to record daily activities with notation of likes/dislikes and what activity is attempted. Notes will be added by sitters and reviewed with new care plan updates after 72 hours by unit coordinator, DON, or Designee. Sitters include staff and R113 family:R113 will continue to receive 1-1 from facility staff and family members who have volunteered to be sitters. A list has been created and family members will be given preference for the times they are available; sitters are to stay with R113 at all times or request a replacement. The list is kept on the SU at the nurses desk. Sitters will be trained verbally at the change of sitter. All sitters anticipate R113s needs and offer divisional activities. Care plans changes will be verbally addressed and ADL sheets updated to reflect changes or modifications. Cart nurse on Lake is in charge of ensuring 1-1 continue and schedule is followed.	

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F 689	Continued From page 32 the fall to ensure interventions were implemented either the same day of the fall or the next morning. The full interdisciplinary team met each Thursday afternoon to review the facility falls. RN-A confirmed R113 was at high risk for falls, suffered from short term memory loss, and did not remember that her hip was broken or why she was required to wear a splint on the wrist. Upon review of R113's falls, RN-A verified R113 had sustained two fractures along with requiring an additional visit to the emergency room following falls. RN-A was able to identify how the facility had updated the care plan after each fall, however, confirmed a comprehensive assessment/reassessment was not completed after each fall in order to determine causal factors and appropriate interventions. RN-A stated R113 continued to be at risk for falls and verified the facility had not implemented frequent documented well-being checks for R113, and had not increased the supervision on the special care unit On 5/22/18, from 7:22 a.m. to 9:25 a.m. R113 was continuously observed sleeping in her bed. -At 9:25 a.m. while R113 was seated on the edge of her bed, NA-B placed a pivot disc (two sided disc utilized to assist in transfers) on the floor in front of R113. NA-B proceed to apply a transfer belt around R113's waist and directed R113 to put her right foot on top of NA-B's foot. NA-D entered the room and the two NAs transferred R113 from the bed to the wheelchair. During the transfer, R113's right foot remained on top of NA-B's foot without noted weight bearing on that extremity. -At 9:30 a.m. R113 was transferred from the wheelchair into the rest room. R113 was again directed to place her foot on top of NA-B's foot for support. R113 was noted to have a 2.0-2.5 inch stapled incision on the right hip.	F 689	Suggested activities were derived from family interview conducted on 5/22/2018 and the admission assessment and include: card playing dominoes wheel chair walk about as well as outside if weather permits sit and visit/drink coffee attend bible study-or chapel services per resident choice plant flowers look at recipe books discuss her travels distract with her doll/baby Lake Staff education: R113 care plan is updated after any change in condition/intervention by the unit coordinator/DON or designee. Any licensed staff can update an intervention and the unit manager/DON will update the focus. All changes are immediately placed on the ADL sheets by the unit coordinator, DON, or designee. The direct care staff utilize UDL sheets to meet the care needs of the residents. Sheets include information on Bath day, bed mobility, transfers, walking, wheelchair use, dressing, eating, toileting, grooming, bathing, incontinent products, side rail/assist bar, dentures, HS routine, and other. All staff caring for R113 on the Lake unit will know her care plan and UDL needs through verbal education at shift change and the updated ADL sheets. Any changes in the care plan will be handed	

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F 689	Continued From page 33 -At 10:07 a.m. with use of a pivot disc, TMA-A transferred R113 from the wheelchair into a recliner in the living room. R113 was not observed to bear weight on the right leg during the transfer. -At 10:51 a.m. RN-A stated the interdisciplinary team had met on 5/21/18, to discuss R113's falls. The IDT had added additional interventions such as folding towels to R113's care plan in order to keep her busy. The staff were also to encourage one to one visits or other activities. When asked how the facility was going to provide one to one supervision as needed, RN-A stated the facility had been working on getting additional staff for the night shift, however, they did not have additional staff for the day or evening shifts to ensure one to one supervision could be provided to R113. RN-A confirmed the facility had not determined a way to provide additional staff for the one to one supervision for R113. The Fall Prevention and Reduction Program dated 1/4/18, directed the staff to provide prompt treatment and prevent further injury following falls. The procedure directed the staff to complete the following step: -A Fall Risk assessment: a form used to asses a resident's risk level for potential falls which was completed at the time of admission and quarterly thereafter. -Incident/Accident Report: an internal form used to report all necessary information regarding a fall or incident. this form was to be completed by the TMA, LPN, or RN as soon as possible following a fall or incident. -RN post Incident Assement: Post incident follow up assessment was to be completed by an RN within 24 hours of the incident. This should include identified risk factors, protocols in place ,and what new or different interventions that were	F 689	off by way of verbal reports/education during each shift changes. New ADL sheets will be printed by the Unit coordinator/DON, or Designee and distributed to the direct staff during the shift change report. Audits: DOS and or designee from Evergreen, Oak, or Valley will conduct scheduled observation audits to ensure 1-1 is being implemented at all times. Times of audit will be random and occur two times each shift. The charge nurse or designee from Evergreen, Oak , and Valley will conduct the random audits. Results will be reviewed DON, unit coordinator or designee. Care plan interventions updated to reflect the following on 5/22/2018: 1-1 sitter at all times. Non pharmacologic use of essential oils that have been provided by the family, coloring, planting, music, group and individual activities of resident preference and choice, visits, coffee, TV watching, with All staff able and encouraged to help with divisional activities. Other activities will be offered per sitter choice taking into account R113 preference. A log is being kept from 5/22/2018 for 72 hours to track R113 likes and preferences for diversion activities. Divisional activates and the 1-1 sitter will be utilized starting on 5/22/2018 to ensure the R113 remains TTWB as per directed. Due to residents cognition resident is not able to be educated and	

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F 689	Continued From page 34 to implemented. -Fall Prevention Protocols: a form which identified numerous fall prevention intervention ideas to be used in conjunction with the RN post Incident Follow Up assessment. -Quality Assurance: QAA committee tracked quality of care provided to resident of the facility and provided recommendations on continued or new protocols for resident quality of life and safety. -Restraint and safety Committees: Committee meets monthly to review falls, protocols, interventions and tracking individual falls. On 5/22/18, at 2:12 p.m. the administrator and the director of nursing (DON) were notified of R113's immediate jeopardy related to repeated falls with injuries and her continued attempts to independently ambulate. -At 3:05 p.m. the DON stated R113 would be provided one to one supervision until full comprehensive assessments could be completed. On 5/23/18, at 8:20 a.m. R113 was observed with a NA-A. One to one supervision provided. The administrator was informed on 5/24/18, at 9:05 a.m. that the immediate jeopardy had been removed on 5/23/18, at 5:30 p.m. after the facility had: -Reviewed the Falls Prevention and Reduction Program policy. -R113 was revaluated by physical therapy. -A comprehensive fall assessment for R113 was completed. -A medication review of R113's medication was completed by the consultant pharmacists. -A Clinical Mobility assessment was completed. -A wandering assessment was completed. -A list of diversional interventions was reviewed and made available for all staff	F 689	she lacks safety awareness. Therefore the sitter and activities will be used to assist with safety. Environmental: 1-1 sitter to remain with R113 at all times. Resident is not to be left alone. Observation audits DON and or designee will conduct scheduled observation audits to ensure 1-1 is being implemented at all times. times of audit will be Random two times per shift for the days R113 is to be non weight bearing. Results will be reviewed by DON, unit coordinator or designee. Activity review for resident preference and choice reviewed Bowel/Bladder review at 72 hours and adjust as needed. DON verified documentation has been completed at the end day of 5/23/2018. R113 is now able to walk. R113 will be seen by OT/PT for strengthening and conditioning. R113 may wear hip protectors if tolerable and per her preference. A 1-1 sitter will remain with R113 until she has more strength and endurance with mobility. Any resident on the Lake unit who has been identified as a high risk for falls has the potential to be affected. Staff rounding has been implemented on the unit. Nursing Staff re-education was completed	

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F 689	Continued From page 35 -One to one supervision with a "sitter" was initiated. -Staff education was provided for all staff working on the special care unit. -R113's care plan was updated -Audits were conducted by the DON and or designee.	F 689	on June 20, 2018 by the DON regarding the following falls protocols: 1. The Fall Risk Assessment: a form used to assess a resident□s risk level for potential falls will be completed at the time of admission and quarterly thereafter or with a significant change. 2. Incident/Accident Report: an internal form used to report all necessary information regarding a fall or incident. This form is completed by the TMA, LPN, or RN as soon as possible following a fall or incident. 3. RN Post Incident Assessment: Post incident follow up assessment is to be completed by an RN within 24 hours of the incident. This should include identified risk factors, root cause analysis, protocols in place and what new or different interventions that were Implemented. 4. Fall Prevention Protocols: a form which presents numerous fall prevention intervention ideas to be used in conjunction with the RN Post Incident Follow Up Assessment. 5. Quality Assurance: QAA committee tracks quality of care provided to residents of the facility and provides recommendations on continued or new protocols for resident quality of life and safety. 6. Falls committee: will review all falls during the weekly meeting 6. Safety Committees: Committee meets monthly to review falls, protocols, Interventions and Tracking of Individual falls. 7. The consulting pharmacist will be	

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F 689	Continued From page 36	F 689	asked to review the medications of any resident who sustains a fall and make any recommendations as appropriate. All residents on the Lake unit who have been identified as a high risk for falls (three or more falls in the past three months) will have a new falls assessment completed by 6/29/2018. Any intervention put in place will be charted on for three days to ensure the intervention is working and appropriate or a new intervention will be implemented. Care plans will be updated as needed. The DON, Unit coordinator, or designee will audit the falls history on Lake to determine which residents meet the criteria for a high fall risk/rate (three falls within the last three months) and ensure the new Falls assessment is completed. Fall risk assessments are done at admission, readmission, or significant change. The Director of Nursing or designee will randomly audit staffing on the Lake Unit to ensure staff compliance with adequate supervision and rounding is occurring. Any Falls noted on the risk management will be audited 5 x week for resident history of falls, fall documentation complete including a root cause, intervention put into place, care plan updated, documentation in the PN indicating effectiveness of the intervention or the need to change the intervention. Falls will be reviewed during the Mon-Fri morning IDT and Audits will be reviewed during the weekly Falls committee	

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F 689	Continued From page 37	F 689	meeting. Audits will be reviewed during QAPI	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance reviews were conducted for 2 of 5 employees (E-I, E-J) reviewed who had been employed over one year. Findings include: The staff listing provided by the facility revealed the following employee hire dates: -Employee (E)-I's hire date was identified as 11/05/07. -E-J's hire date was identified as 5/17/13. On 5/24/18, at 9:35 a.m. the director of nursing (DON) stated she was responsible to conduct the staff's annual performance reviews and confirmed the aforementioned employees lacked annual performance reviews. The DON stated the facility did not have a system in place to monitor and track in-service training's or employee evaluations. The DON stated the facility was	F 730	The policy requiring annual performance appraisals for staff who have been employed by PMCC for at least 1 year was reviewed. All residents had the potential to be affected. Facility corrective action included all CNAs having been employed by PMCC for 1 year or more will have a performance appraisal completed. Audits will be completed by the DON or designee of the CNAs' hire dates and need for a performance appraisal. Audits will be completed 1x week x 2 months Audits will be reviewed during QAPI	6/29/18

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F 730	Continued From page 38 seeking a human resource employee to assist with staff training and evaluations. On 5/24/18, at 10:13 a.m. the Administrator confirmed it was her expectation that staff received performance reviews annually. A policy related to performance reviews was requested, however, none were provided.	F 730		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure target behavior	F 757	PMCC policy for medication regimen monitoring was reviewed and updated to	6/29/18

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F 757	Continued From page 39 monitoring was analyzed in order to determine medication efficacy and continued need for 1 of 1 male resident (R31) who received female hormones in an attempt to manage maladaptive sexual behaviors. Findings include: R31's significant change Minimum Data Set (MDS) dated 3/27/18, identified R31 with diagnoses including dementia, major depressive disorder, prostate cancer and anxiety disorder. The MDS indicated R31 displayed behaviors which included verbal and physical abuse towards others and required extensive assistance of one staff for all activities of daily living. R31's Delirium Care Area Assessment (CAA) dated 4/5/18, indicated R31 had diagnosis of dementia and bipolar disorder which impacted his cognition and mood as well as behaviors. R31's dementia was not anticipated to improve and he was orientated to self only. R31 frequently identified staff members as his wife, sisters or high school friends. R31 identified his roommate as his father. R31's Behavioral CAA dated 4/5/18, indicated R31 displayed physical and verbal aggression toward others which was typically in combination with rejection of personal cares required to meet his safety and heath needs. R31 had regular instances of wandering. The CAA indicated the staff were to encourage and to also explain cares to R13 which at times, was proven futile. The assessment directed the staff to reapproach R31 at a later time, if needed. R31's Order Summary Report dated 5/23/18,	F 757	include target behavior monitoring. The policy also addresses unnecessary drug monitoring, excessive dose, excessive duration, indications for use, adverse consequences, and any combination. All male residents receiving female hormones in an attempt to manage maladaptive sexual behaviors had the ability to be affected. Facility corrective action included updating the medication monitoring policy to include target behavior monitoring. Nursing staff will be educated on the policy and procedure by the DON on 6/20/2018. The Pharmacy consultant reviewed R31 list of medications and made recommendation which were passed on the primary physician for a medical review. All males receiving female hormones will be audited for target behaviors and analyzed in order to determine efficacy and continued need. Audits will be conducted by the DON or designee 3 x weekly for 1 month, 2 x weekly for 2 weeks and 1 x week for 1weeks. Audits will be reviewed during QAPI	

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F 757	Continued From page 40 included an order for Premarin (female [estrogen] hormone) 0.625 milligrams daily for the treatment of paraphilia (a condition characterized by abnormal sexual desires, typically involving extreme or dangerous activities). The order had originally started on 8/29/14. R31's Care Plan received on 5/23/18, indicated R31 displayed socially inappropriate/disruptive behaviors and occasionally displayed sexually inappropriate verbal and physical behaviors. The plan directed the staff to ensure R31 had a private are to masturbate, to redirect if displaying inappropriate behaviors, enjoyed sing along's which helped distract him, and to offer R31 chewing gum as it quickly distracted him, and when irritable to ensure that other residents are not near him. During observations of R31 throughout the survey on 5/20/18, from 1:00 pm. to 8:00 p.m., on 5/21/18, from 8:00 a.m. to 4:30 p.m., on 5/22/18, from 7:00 a.m. to 4:00 p.m., on 5/23/18, from 8:00 a.m. to 4:30 p.m. and on 5/24/18, from 8:00 a.m. to 1:00 p.m. R31 was observed to reside on the special care unit. He was quiet and tended to stay in his room or the family room. R31 did take occasional rest periods on the living room couches but was not observed to display any type of maladaptive sexual behaviors towards staff, residents or visitors. Review of R31's progress notes revealed the following: -On 11/7/17, at 8:30 p.m. R31 asked a young staff member "Hey, can I see you naked?' -11/27/17, at 1:53 p.m. R31 asked a homemaker if he could see her naked and asked a nurse if he could see her groin. The staff member informed him that this was not a very nice way to talk to others.	F 757		

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F 757	Continued From page 41 -On 2/14/18, at 9:49 p.m. R31 asked a nursing assistant (NA) if he could see her naked and invited the staff member to his room. -On 2/22/18, at 3:30 p.m. R31 asked a nurse if she would come and lay with her on the couch. R31 was easily redirected. A few moments later, R31, again asked the nurse if she could come and lay with him on his bed. -On 2/23/18, R31 grabbed an unidentified NA's groin. -On 3/6/18, at 2:10 pm. R31 grabbed an unidentified NA's buttocks and breast during cares. -On 3/2/18, at 2:39 a.m. R31 grabbed the nurses buttocks. The nurse informed him that this was not appropriate. R31 was noted to have a flat affect. A few moments later, R31 was noted to be entering another resident's room. When the staff attempted to redirect him, R31 placed his hand around the neck of the staff member. When the staff redirected him, R31 laughed in the staff members face. R31's psychiatric evaluation dated 12/2017, indicated R31 could potentially be considered for a reduction in the Premarin however, it had been identified for slowing the rate of prostate cancer. The psychiatrist indicated R31 was to be re-evaluated in four weeks. No further psychiatric evaluations were noted in R31's record. Review of R31's behavior monitoring conducted in the Point of Care electronic record for March, April and May 2018, indicated R31 had not displayed any type of sexually inappropriate behaviors. Review of R31's clinical record lacked an analysis of R31's behaviors in relationship to the continued	F 757		

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F 757	Continued From page 42	F 757		

use of Premarin.

On 5/23/18, at 10:25 a.m. trained medication assistant (TMA)-A stated she could not recall the last time R31 had displayed sexually inappropriate behaviors. TMA-A stated it had been a "long long time."

-At 10:28 a.m. NA-A stated R31 would occasionally be resistive to cares, he would pat staff members arms and or legs and could make snide remarks during cares, but NA-A did not feel any of the behaviors or comments were in a sexual nature.

-At 12:52 p.m. the consultant pharmacist stated he did not know why R31 was on Premarin as it was his first visit to the facility. The pharmacist stated he would look into it.

The Consultant Pharmacist Review dated 5/23/18, indicated R31 was on Premarin for the treatment of prostate cancer.

On 5/23/18, at 2:30 p.m. registered nurse (RN)-A stated R31 was not currently displaying sexual behaviors, however, confirmed the medication was initially started for the treatment of the sexual behaviors, however it was determined to have a second advantage of decreasing the growth rate of R31's prostate cancer.

On 5/23/18, at 3:20 p.m. RN-C stated R31 did have a history of sexually inappropriate behaviors, however, they had decreased in the past few months. RN-C stated R31's behaviors in relationship to the medications were reviewed for the seven day look back period required during an MDS assessment. RN-C stated the

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F 757	Continued From page 43 nursing assistants document the behaviors on a daily basis, however, nobody reviewed the behavior documentation. Since R31 had been started hospice services, R31 was no longer receiving psychiatric services. RN-C confirmed the clinical record lacked an analysis of the behaviors in relationship to the medications used to treat the behaviors. A policy related to medication regimen monitoring was requested and none was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		6/29/18

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	245301	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL CARE CENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535

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F 758	Continued From page 44 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to analyze maladaptive behaviors for 2 of 4 residents (R30 and R57) who were receiving psychotropic medications for behavioral management. Findings include: R30's annual Minnimum Data Set (MDS) dated 3/27/18, indicated R30 had diagnoses including dementia, depression and an unspecified mood disorder. The MDS indicated R30 had severe cognitive impairment and displayed verbal and physical aggression towards others and required extensive assistance of two staff for all activities	F 758	A policy psychotropic medication regime use was reviewed and updated to include behavior monitoring. All residents who are taking a Psychotropic drug have the potential to be affected. Facility corrective action included staff in the nursing department were trained on the policy for medication regimens and monitoring which includes behavior monitoring. Training was provided by the DON on 6/20/2018.A review of the PRN 14 day rule and GDR will be discussed.	

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F 758	Continued From page 45 of daily living. The MDS also indicated R30 received daily antipsychotic medications. R30's Cognition Care Area Assessment (CAA) dated 3/27/18, indicated R30 had episodes of disorganized thinking in which he had difficulty focusing his attention on what was being said to him. The staff were to provide orientation and reassurance to him as necessary to decrease anxiety with memory impairment. R30's Behavioral CAA dated 3/27/18, indicated R30 displayed verbal aggression towards others such as cursing, yelling and name calling as well as physical aggression such as grabbing and twisting the arms of the care givers. The CAA indicated the behaviors increased while personal cares were provided to R30. R30's Psychotropic Medication CAA dated 3/27/18, indicated R30 utilized Seroquel (an antipsychotic medication) for the management of behavioral symptoms. R30's Order summary Report dated 5/23/18, indicated R30 utilized Seroquel 25 milligrams (mg) twice a day for restlessness and agitation. R30's care plan received on 5/24/18, indicated R30 displayed behavior symptoms on a regular basis. The behaviors included verbal and physical aggression towards others and wandering. The plan directed the staff to explain cares to allow him time to comprehend the task to be completed. The care plan also directed the staff to monitor and record occurrences of target behaviors such as pacing, wandering and violence/aggression towards others.	F 758	Monitoring will include:1) identification of problem behavior, 2) patient assessment, 3) specific systematic behavioral interventions, 4) documentation of outcomes for behavioral interventions, and 5) necessary adjustments of program based on observed results. Any noted areas of concern will be addressed with the consulting pharmacist on a monthly basis or the medical provider. A psychotropic medication assessment and mood and behavior assessment was completed for R30 and R57. The Pharmacy consultant reviewed R30 and R57 medications and made recommendations which were passed on to the medical provider for further follow up. Audits will be performed by the DON and designees of the residents receiving psychotropic drugs to review 1) identification of problem behavior, 2) patient assessment, 3) specific systematic behavioral interventions, 4) documentation of outcomes for behavioral interventions, and 5) necessary adjustments of program based on observed results. Audits will be reviewed during QAPI	

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F 758	Continued From page 46 R30's Progress Notes revealed the following: -2/26/18, at 8:40 p.m. R30 was noted to holler out during the shift. Was able to calm when given a baby doll. -2/27/18, at 1:42 p.m. R30 was noted to be yelling out. The staff provided him with additional breakfast cereal. -3/3/18, at 11:15 p.m. R30 yelled out at staff. The staff offered him additional food and drink, offered R30 a baby doll to hold and assisted with toileting. The staff offered him different activities, however, R30 continued to yell out without response to redirection. -3/8/16, R30 yelled out during most of the night shift. R30 was allowed to sit in the living room and offered to rest in his bed. R30 continued to yell out at others. -3/31/18, R30 yelled out during the night shift. -4/17/18, R30 yelled during the night shift and did strip off all of his clothes. The staff offered him breakfast cereal and he was able to go back to sleep. -5/8/18, at 5:09 a.m. R30 was yelling out and resistive to cares while being toileted on the night shift. R30 calmed after he was assisted to bed. During the survey conducted on 5/20/18, from 1:00 p.m. to 8:00 p.m., on 5/21/18, from 8:00 a.m. to 4:30 p.m., on 5/22/18, from 7:00 a.m. to 4:00 p.m. on 5/23/18, from 8:00 a.m. to 4:30 p.m. and on 5/24/18, from 8:00 a.m. to 1:00 p.m. R30 was not observed to be resistive with cares or display verbal or physical aggression towards others. R30 held a baby doll during most activities and was observed to talk to the baby doll off and on. Review of the nursing assistant behavioral documentation in Point of Care computerized	F 758		

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F 758	Continued From page 47 medical record revealed the NA's monitored R30 for behaviors which included crying, repetitive movements, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behaviors, sexually inappropriate, and rejections of care. The Documentation Survey Reports v2 (NA behavioral documentation) revealed the following: -March 2018, R30 displayed 16 episodes of yelling out and one occasion of rejecting care. -April 2018, R30 displayed 14 episodes of yelling out, one episode of rejection of care and 14 episodes of grabbing at others. - May 1-24, 2018, R30 displayed 8 episodes of yelling out. Review of R30's medical record lacked an analysis of R30's behaviors in relationship to the prescribed medications. On 5/24/18, at 9:57 a.m. registered nurse (RN)-A stated R30 displayed verbal and physical aggression towards others especially while personal cares were being performed. The NA's recorded the behaviors as they occurred. The documented behaviors were then reviewed with the physician. However, RN-A verified the facilty did not have a system in place to analyze the behaviors in relationship to the medications which had been prescribed to manage the behaviors. On 5/24/18, at 10:08 a.m. the director of nurses (DON) confirmed the facility did not have a have system to analyze the behaviors in relationship to the prescribed medications.	F 758		

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F 758	Continued From page 48 A policy for behavior monitoring and analysis of the behaviors was requested and none was provided.	F 758		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of	F 791		6/29/18

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F 791	Continued From page 49 dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were obtained for 1 of 1 resident (R10) identified with dental concerns and who was receiving Medicaid Services. Findings include: R10's annual Minimal Data Set (MDS) dated 3/1/18, indicated R10 had intact cognition, had no natural teeth or tooth fragments, had no chewing problems, no mouth sores and no reported no weight loss. R10's Dental Care Care Area Assessment (CAA) dated 3/1/18, indicated R10 was edentulous, had an upper denture plate but, had lost the lower plate. Nursing staff are helping R10 in searching for the missing plate. The CAA also indicated R10 was responsible for his dentures and was not distressed about missing the lower plate. R10's Nutrition assessment, dated 2/26/18, indicated R10 required a mechanical soft diet with regular consistency meat with no green beans, corn, peas. The assessment also indicated R10 was independent with eating.	F 791	Facility policy for lost or damaged dentures was reviewed. All residents with lost or damaged dentures have the ability to be affected. Facility corrective action included the Social worker and Nursing staff were retrained on our policy which states an appointment will be made within 3 days of a reported lost denture if the resident requests one and that the diet will be modified if needed or requested in order to maintain proper nutrition by the Administrator. R10 was responsible for the loss of his own lower denture. The facility is not liable for the replacement cost per the facility policy. The Social worker investigated payment sources for the resident through VA services as well as his guardian LSS. The SW also contacted the health plan care coordinator. The care coordinator said the R10s insurance will only cover a dew denture every 6 years. R10 will not have coverage for a new denture. A dental appointment was secured for R10. R10 was assisted in arranging	

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F 791	Continued From page 50 R10's current electronic care plan, revised on 3/2/18, indicated R10 was edentulous, had a upper denture plate with appropriate fitting. R10 is missing the lower plate. R10 was independent with oral cares and was responsible for the dentures. The care plan also indicated R10 was not concerned about the missing lower denture. The plan directed staff to encourage oral cares, ensure R10 has oral care supplies, assist with denture care as needed, and review R10's dental status quarterly and as needed and assist with making dental appointments as needed. R10's Order Summary dated 5/23/18, revealed an order dated 12/22/15, which indicated mechanical soft, regular consistency, level II dysphagia (difficulty swallowing) -regular meat and was not to receive green beans, corn, peas or other small pieces of food items. The Order Summary also indicated R10 had diagnoses which included Gastroesophageal reflux (GERD), cough, constipation, and was oxygen dependent due to chronic obstructive pulmonary disease (COPD). On 5/21/18, at 3:13 p.m. R10 was observed to not have a lower denture in place. R10 stated approximately one year ago he had lost his lower denture plate. R10 also stated although he wore an upper plate, he had difficulty chewing foods and experienced occasional mouth sores. R10 stated he would like to have lower plate in order to improve his personal appearance as well as to be able to eat all foods, with better digestion. R10 denied receiving any dental services at the facility, but stated he was willing to go out to the community dental office dental care. R10 was uncertain who would pay for the replacement of lower denture and approximately one month ago,	F 791	transportation to the dental clinic in Bemidji.R10 was informed that the consistency of his food can be altered if he has any difficulty with chewing or experiences discomfort from his food. R10 is cognizant and will ask if he desires a change in hid diet textures. The social worker or DON will monitor and ensure that any resident who loses a denture and wants a dental appointment will have an appointment made within 3 days of reporting the loss. Dietary changes and modifications will also be addressed. A log of reports of missing dentures will be maintained and reviewed for any trends. Any reports of missing dentures will be reviewed during QAPI.	

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F 791	Continued From page 51 he independently, had contacted Veteran Services for assistance with his dental needs and was currently waiting a response. On 5/22/18, at 10:53 a.m. the licensed social worker (LSW) stated she would contact Veterans Services and/or Medicaid in order to determine financial coverage of a lower denture place for R10. On 5/24/18, at 9:49 a.m. Registered nurse (RN)-F stated the Medicaid dental provider had told her that R10 must wait six years for replacement of the lower denture plate. When asked if the Medicaid provider was informed of R10's dental status and limitations to eating due to the missing denture, RN-F stated she was unaware if the provider was given the necessary data in order to expedite replacement of the denture. Policy for Lost or Damaged Dentures Pioneer Memorial Care center, stated "the facility shall help obtain from an outside resource routine and emergency dental services to meet the needs of each resident." "It is the policy of Pioneer Memorial Care Center to ensure that Dental Appointments will be scheduled within three business days of a resident's dentures being noted to be lost or damaged."	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		6/29/18

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F 880	Continued From page 52 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 53 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform hand hygiene during the provision of personal cares for 1 of 7 residents (R4) observed to receive cares. In addition, the facility failed to ensure appropriate soiled linen handling for 2 of 7 residents (R4 and R113) observed to receive personal cares. Findings include: R4's annual Minimum Data Set (MDS) dated 2/15/18, indicated R4 had diagnosis of dementia, diabetes mellitus and hemiplegia (paralysis of one side). The MDS indicated R4 required extensive assistance of two staff for all activities of daily living. On 5/22/18, at 8:35 a.m. nursing assistant (NA)-B	F 880	The facility policies for hand washing and handling soiled linen was reviewed and are appropriate. All residents had the potential to be affected. Facility corrective action included immediate retraining of NA-B and NA-D on the proper use of gloves, hand hygiene, and safe bagging, and transporting of dirty linen for infection control. Remaining nursing department staff were retrained on infection prevention, proper use of gloves,hand hygiene and proper handling dirty linens by the DON on 6/20/2018.	

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F 880	Continued From page 54 and NA-D were observed to perform personal cares for R4 while in bed. Both NAs were noted to be wearing gloves as they assisted R4 to wash and dress his upper body. The NAs were observed to wear gloves while they assisted R4 to wash and dress his upper body. -At 8:39 a.m. with the same gloved hands, the NAs removed R4's incontinent brief and proceeded to provide perineal care. Upon rolling R4 onto his side, R4 was noted to have been incontinent of bowel in which the NAs proceeded to clean R4's buttocks. Upon completion of the cares, the NA's placed the dirty linens which included the towels, washcloths, and a sheet, directly onto the floor. Both NAs removed their gloves but did not wash their hands. -At 8:46 a.m. the NAs transferred R4 from bed to a wheelchair via a full body mechanical lift. Following the transfer and with bare hands, NA-D picked up the soiled linen from the floor and placed them into a plastic bag. -At 8:48 a.m. NA-B entered R4's bathroom, removed a cup containing dentures and began to drain the water off. NA-B confirmed she had not washed her hands after completing the perineal cares and prior to touching the denture cup. NA-B put the denture cup down and proceeded to wash her hands, donned fresh gloves and resumed assisting R4 with placement of the dentures. -At 8:53 a.m. R4 was wheeled to the dining room. R113's admission Minimum Data Set (MDS) dated 3/28/18, indicated R113 had diagnosis including Alzheimer's dementia, anxiety disorder and atherosclerotic heart disease. The MDS indicated R113 required supervision with all activities of daily living.	F 880	Any incidents of infections are tracked per wing by the DON and reviewed for any patterns or trends. Random hand washing audits will be assigned 4x week x 2 weeks on all 3 shift, when compliance is attained audits will continue for 2x week x 2 weeks, 1x week x 1 week on all shifts. Safe Linen handling audits will be assigned to various staff members to complete. Audits will be completed 3 x weekly for 1 month, 2 x weekly for 2 weeks and 1 x week for 1weeks. Audits will be reviewed by the DON and the Safety committee will determine if addition audits or staff training is needed. Audits will be reviewed during QAPI	

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F 880	Continued From page 55	F 880		

On 5/22/19, at 9:26 a.m. R113 was observed seated on the edge of her bed as NA-B and NA-D provided personal cares. R113's incontinent brief and soaker pad which was positioned under her were noted to be saturated with urine.
-At 9:32 a.m. NA-A and NA-B transferred R113 out of the bed and into a wheelchair. NA-D placed the soiled soaker pad directly on the floor next to R113's bed. The NA's assisted R113 to the restroom and proceeded to complete personal cares.
-At 9:43 a.m. NA-D made R113's bed and picked up the soiled linens off the floor. NA-D placed them into a plastic bag and carried them out of the room.

On 5/22/19, at 10:28 a.m. NA-B verified she and NA-D had placed the soiled laundry directly on the floor and stated they should not have.

On 5/23/18, at 3:35 p.m. registered nurse (RN)-C stated the staff were to wash their hands between the completion of perineal cares and prior to starting oral cares. RN-C also stated the staff were not to place soiled laundry on the floor of a resident room, rather the staff were to place the soiled linens directly into a plastic bag or a laundry hamper.

The Hand Washing policy revised on 5/22/18, directed the staff to wash their hands to prevent the spread of infection and diseas to other residents, employees and visitors. The policy also indicated the staff were to wash their hands after assisting resident with there personal bodily functions.

The Contaminated Linen policy revised on 5/22/18, directed the staff to place soiled linens

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	245301	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL CARE CENTER	23028 - 347TH STREET SOUTHEAST ERSKINE, MN 56535

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F 880	Continued From page 56 directly into a linen hamper/barrel or into a sealed garbage bag for the services in the central laundry area.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 nursing assistants (NA-H, NA-I, NA-J, NA-K) completed the required 12 hours of in-service training annually. Findings include: Review of nursing assistant (NA)-K's personnel file indicated a hire date of 7/28/16. NA-K's file revealed evidence of 0 hours of in-service training	F 947	The relias learning logs were reviewed for all CNAs to see who was lacking 12 CEUs of required in-service. A facility policy was developed relating to staff training and in-service requirements. All residents have the potential to be affected. Facility corrective action included	6/29/18

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F 947	Continued From page 57 completed for 2017. Review of NA-J's personnel file indicated a hire date of 11/28/07. NA-J's file revealed evidence 0 hours of in-service training completed for 2017. Review of NA-I's personnel file indicated a hire date of 5/16/13. NA-I's file revealed evidence of only one hour of in-service training completed for 2017. Review of NA-H's personnel file indicated a hire date of 3/24/11. NA-H's file revealed evidence of only one hour of in-service training completed for 2017. On 5/24/18, at 9:35 a.m. the director of nursing (DON) stated the facility utilized an online training program for monthly in-service training for the nursing assistants. The DON stated other training's had been held, however, no documentation was available related to those training's as the facility currently had no process in place for the management or monitoring of in-service training's. The DON confirmed nursing assistants were required to have 12 hours of in-service education annually and verified the aforementioned employees did not have the 12 hours, as required. On 5/24/18, at 10:13 a.m. the Administrator confirmed it was her expectation that staff received the 12 hours of in-service training annually, as required. A facility policy related to annual training was requested, none was provided.	F 947	re-education conducted by the DON on 6/20/2018 including addressing that 12 credits are due by the CNAs within 12 months of their hire dates and not the calendar year. All CNAs were reassigning any outstanding learning center required courses. NA-H, NA-I, NA-J, NA-K completed 12 hours of Relias training. A spreadsheet will be created and maintained by the DON or designee for all the CNAs and their dates of hire to monitor compliance with the required in service trainings. Random audits of the learning center completion logs will be completed by the DON or designee to ensure courses are being completed on a monthly basis as assigned. Staff will be given verbal or written reminders if noted to be behind on the assigned learning center trainings. Audits will be reviewed during QAPI	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2018

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was inspected as one building. Pioneer Memorial Care Center was built in 1985, is one story with a partial basement and was determined to be Type V(111) construction. In 1997 a 1-story addition was constructed to the east of the original building with out a basement, was determined to be Type V (111) construction and which is separated with a 2-hour fire barrier. In 2005 an 1-story addition was constructed to the south of the original building that has a full basement and was determined to be a Type V (111) construction. The facility is protected with a complete automatic sprinkler system and has a fire alarm system with corridor smoke detection and smoke detectors in	K 000		

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K 000	Continued From page 2 all common areas, installed. Additional single smoke detectors are in all sleeping rooms of the 2005 addition, the remodeled east wing and hazardous areas have automatic fire detection. The facility has a capacity of 68 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	K 131		6/19/18

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K 131	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 05/21/2018 observations revealed the 2 hour fire barrier connecting the assisted living to the nursing home had a 2 1/2 inch diameter hole above the ceiling at the cross corridor doors that was not properly fire stopped. This deficient condition was confirmed by the Facility Administrator and Maintenance personnel.	K 131	In compliance with the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3.The maintenance staff repaired the 2 1/2 inch diameter hole found in the 2 hour fire barrier connecting the assisted living to the nursing home with sheetrock and caulked to ensure that no smoke or fire from another occupancy would transfer through the noted hole.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351		6/19/18

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K 351	Continued From page 4 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to install sprinkler heads in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of 16 of 68 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 05/21/2018 observations revealed a mechanical room in the memory care wing has duct work over 4 feet in width without the proper sprinkler coverage under it. This deficient condition was confirmed by the Facility Administrator and Maintenance personnel.	K 351	A sprinkler head was installed in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems in the mechanical room in the memory care wing which had duct work over 4 feet in width without the proper sprinkler coverage under it.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372		6/19/18

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K 372	Continued From page 5 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of five smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 22 of the 68 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 05/21/2018 observations revealed the smoke barrier for the Main Street wing had a 1 inch diameter hole above the ceiling at the cross corridor doors without the proper fire stopping. This deficient condition was confirmed by the Facility Administrator and Maintenance personnel.	K 372	The maintenance team repaired the 1 inch diameter hole above the ceiling at the cross corridor doors by means of new sheetrock and fire resistant caulking to ensure smoke would not be able to transfer from one smoke compartment to another.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		6/19/18

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K 918	Continued From page 6 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 68 residents and an undetermined amount of staff and visitors if the generator failed to operate	K 918	The 2012,edition of the Life Safety Code (NFPA 101)section 9.1.3.1 and the 2010 edition of NFPA110 the Standard for Emergency and Standby Power Systems was reviewed with regards to the emergency test documentation for the generator. Facility corrective action included: Re-education of the maintenance personnel on maintaining a	

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K 918	Continued From page 7 during a power outage. Findings include: On the facility tour between 9:00 am to 1:00 pm on 05/21/2018 record review revealed the weekly visual inspection was documented as being completed only once a month. This deficient condition was confirmed by the Facility Administrator and Maintenance personnel.	K 918	weekly visual inspection log. Recording the Emergency and Standby Power Systems log on a weekly basis will be completed by maintenance personnel	