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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3O28

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245528**

2. STATE VENDOR OR MEDICAID NO. (L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **6/6/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (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
	43			
(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 :
Danette Bakken, HFE II 06/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/10/2016 (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 **04/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245528

June 8, 2016

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

Dear Mr. Samuelson:

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 May 31, 2016 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

June 8, 2016

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

RE: Project Number S5528026 and Complaint Number H5528006

Dear Mr. Samuelson:

On May 13, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 18, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on March 18, 2016, that included an investigation of complaint number H5528006, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on May 3, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on May 3, 2016, as of May 31, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 31, 2016. In addition, at the time of the June 6, 2016 revisit the Minnesota Department of Health completed an investigation of complaint number H5528007 that was found to be unsubstantiated.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 13, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 18, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

Medicare admissions, effective June 18, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 17, 2016, is to be rescinded.

In our letter of May 13, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 18, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 31, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245528		6/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 05/31/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 05/31/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 6/8/2016	SIGNATURE OF SURVEYOR 32980	DATE 6/6/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3O28

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245528**

2. STATE VENDOR OR MEDICAID NO. (L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **5/30/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	43			
(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 :
Christina Smith, HFE NE II 5/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 6/8/2016 (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 **04/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 13, 2016

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

RE: Project Number S5528026 and Complaint Number H5528006

Dear Mr. Samuelson:

On April 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 18, 2016 that included an investigation of complaint number H5528006. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 3, 2016, the Minnesota Department of Health and on May 4, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 27, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 18, 2016. The deficiencies not corrected are as follows:

F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective May 18, 2016. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions

must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 18, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 18, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 18, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Gundersen Harmony Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 18, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711
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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 allegation of compliance and/or 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.brown@cms.hhs.gov.

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 June 18, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on May 2 & 3, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive bladder	{F 315}	For Resident #51- the assessment was missing as indicated, but the assessment	5/31/16

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

Electronically Signed | 06/01/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	Continued From page 1 assessment was completed and care plan interventions based on these assessments following a decline in bladder function for 1 of 3 residents (R51) reviewed for urinary incontinence. Findings Include: R51's face sheet indicated R51 was diagnosed with dementia. R51's admission Minimum Data Set (MDS) dated 11/26/15, indicated F51 had moderate cognitive impairment, no behaviors, required extensive assist of one staff for transfers and toileting, was occasionally incontinent of urine and had no toileting program attempted. R51's quarterly MDS dated 2/17/16, indicated R51 had moderate cognitive impairment, no behaviors, required limited assist of one staff for transfers and toileting, was frequently incontinent of urine and had no toileting program attempted. R51's quarterly bowel and bladder assessment dated 2/17/16, indicated R51 had frequent urinary incontinence, required one staff physical assistance to toilet, had diagnosis of Alzheimer's disease, urge and stress incontinence to direct staff to continue with the current care plan. Although requested, no copy of the assessment was provided. R51's care plan dated 2/2/16, indicated R51 had occasional urinary incontinence, R51 liked to be independent with toileting, had resisted cares and directed staff to provide incontinence care after each incontinence episode and assist as able. R51's care plan with a revised date of 4/25/16, included R51 was occasionally incontinent of	{F 315}	has now been completed as indicated by the plan of correction. His care plan is updated. Furthermore, a meeting was held with facility CNA staff on May 25, 2016 and the importance of incontinence care and toileting schedules were reviewed. The care of resident #51 was included in that instruction. The previous plan of correction was reviewed again with the Nurse Managers to assure their understanding of the plan to avoid further problems.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	Continued From page 2	{F 315}		

bladder. 4/25/16 care plan information added was history of prostate Cancer with radical removal- may result in difficulty retaining urine at times. An intervention dated 2/2/16, directed staff to offer assistance to toilet every two hours to assist with changing of brief and good pericare especially after incontinence. He can be resistive to assist. Observe for when he is on the toilet and offer assistance.

R51's quarterly bowel and bladder assessment dated 2/17/16, indicated R51 had frequent urinary incontinence, required one staff physical assistance to toilet, had diagnosis of Alzheimer's disease, urge and stress incontinence to directed staff to continue with the current care plan.

On 5/03/16, at 9:56 a.m. registered nurse (RN)-B confirmed the plan of correction for R51 from the initial survey (exited 3/18/16) indicated R51's incontinence issues would be further assessed and his care plan would be updated to reflect his current condition by 4/27/16, and confirmed this had not been completed. RN-B also confirmed the facility had done nothing to attempt to restore R51's bladder function after a decline in urinary incontinence

On 5/03/16, at 10:37 a.m. the director of nursing (DON) confirmed the plan of correction for R51 from the initial survey indicated R51's incontinence issues would be further assessed and his care plan would be updated to reflect his current condition by 4/27/16, and confirmed this had not been completed as written on the plan of correction (POC). The DON stated she expected the nurse to re-due the bladder assessment and update the care plan according to the findings. The DON stated the facility did not have a policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	Continued From page 3 and procedure related to urinary incontinence. Document review of facility assessment and care plan protocol policy, undated, revealed the following: "Furthermore, if the resident's condition requires special assessments not ordered by the physician, we add nursing orders to cover those additional needs specific to what is required by the resident's condition." Further assessments- "We follow the protocol called for by CMS (Centers for Medicare and Medicaid Services) to complete the following on or before the ARD (assessment reference date) date (nurse manager to determine special needs if a particular assessment needs to be done immediately-for instance, a new admit requests to self-administer medications on the first day." Nursing care plan-"We follow the regulations that state a comprehensive care plan is to be developed within seven days. To fill the gap during those seven days, we utilize the physician orders as an initial plan of care related to medications, diet, activity/transfers, special assessments and treatment." Care plan updates-" Care plans are to be updated on a quarterly basis or sooner if a significant change is noted." Expectations of staff following care plans- "We expect that all licensed staff have an understanding that care plans are a standard nursing practice and they should not require special policies that tell them to follow a care plan. This is a matter of licensure and all nurses receive this training." "All CNA (certified nursing assistant) staff receives education upon starting at the facility and throughout their employ that there is a plan of care and the most current plan for the CNA can be accessed via the computer kiosk."	{F 315}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

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{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	{F 441}		5/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure inhalation nebulizer equipment was cleaned and stored appropriately to decrease/prevent the risk of infection for 2 of 3 residents (R2, R41) observed to have nebulizers. R2 was in the sample cited during the survey exited 3/18/16 and R41 was new to the sample observed during this PCR survey. Findings: R2's room was checked during the initial tour on 5/2/16 at 9:05 a.m. R2's nebulizer machine was placed in the nebulizer holder and had visible condensation in the reservoir holder and mouth piece. Observation of R2's nebulizer equipment being store incorrectly was verified by a second surveyor during initial tour. R2's Physician Orders included, Ipratropium-Albuterol solution by nebulizer: 0.5 mg (milligrams) 3 mg/3 ml (milliliters) one vial inhalation. Administer at 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m. and twice per day as needed for cough/dyspnea/wheezing. R41's room was checked during the initial tour on 5/2/16 at 9:05 a.m. R41's nebulizer machine was placed in the nebulizer holder. The medication reservoir chamber was ¼ full of clear liquid. Observation of R41's nebulizer equipment being store incorrectly was verified by a second surveyor during initial tour. R41's Physician Orders included, albuterol sulfate solution by nebulizer: 2.5 mg (milligrams) 3 ml (milliliters) one vial inhalation. Administer three times a day in morning, noon, before bed and may have every four hours as needed for	{F 441}	Nursing staff have been instructed on a one to one basis that they should not bring the nebulizer solution to the room of residents who "self-administer" until the person is ready to utilize the nebulizer. This will prevent the solution sitting in the room for an extended period of time. Furthermore, each resident who is "self-administering" nebulizers has been asked to turn their call light on when they have completed the treatment. Nurses have been instructed that they should attempt to stay in the area working so that they can return to the room to clean the nebulizer as soon as the treatment is complete. Additionally, a CNA meeting was held on May 26, 2016 and CNA staff were instructed to notify a nurse or TMA if they notice a resident has completed their nebulizer treatments and the nebulizer cup is ready for cleaning. We have continued to do intermittent audits to assure the new procedure is followed and do on the spot re-education as needed. For any person who does not "self-administer", nurses/TMAs have been instructed that they must remain with that person during the treatment and clean the equipment after the treatment is complete. We will continue to do audits and continue to educate staff as any audit may indicate per our original plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 441}	Continued From page 6 wheezing. During an interview on 5/2/16 at 9:29 a.m. the director of nursing stated she expected nebulizer equipment to be cleaned and stored appropriately after each use. The Nursing Skills Nebulized Medication and Equipment Care policy dated 4/20/16, instructed staff, "...12. When a treatment had ended turn off the air compressor ...13. Disconnect the oxygen tubing and set aside. 14. Disassemble nebulizer. 15. Soak nebulizer pieces in warm soapy water approximately for 20 minutes. 16. Rinse each piece with warm soapy water for approximately 20 minutes. 16. Rinse each piece with warm water. 17. Let air-dry on a clean paper or cloth towel. 18. When piece are dry store in a clean/dry plastic bag ... The Manufacturer's instructions for the nebulizer machine and components included instruction on cleaning, disinfecting, and sterilizing the nebulizer components and accessories. Instructions directed staff to: 1) Disconnect the tubing from the compressor and from the bottom of the nebulizer cup. 2) If there is any moisture in the tubing, let the compressor run with tubing only 2-3 minutes or dry the tubing by removing it from the compressor and hanging up with the ends down to allow the moisture or to drain out. Use a clean damp cloth to wipe exterior of the machine. 3) Disassemble tubing and accessories 4) Wash all parts with warm water and liquid dish soap and don't wash the tubing. 5) Rinse thoroughly with warm water and shake out water 6) Air dry or hand dry nebulizer parts on a clean, lint free cloth. Reassemble nebulizer parts when	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	R 05/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

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{F 441}	Continued From page 7 parts are dry and store. The instructions directed staff to disinfectant and sterilize the equipment for one hour every other treatment day using one distilled vinegar to three parts hot tap water and store as above.	{F 441}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245528 Y1	A. Building B. Wing Y2	5/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	03/27/2016	LSC	04/27/2016	LSC	04/27/2016
ID Prefix F0278	Correction	ID Prefix F0280	Correction	ID Prefix F0281	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(i)	Completed
LSC	04/27/2016	LSC	04/27/2016	LSC	04/27/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(h)	Completed
LSC	04/27/2016	LSC	04/27/2016	LSC	04/27/2016
ID Prefix F0329	Correction	ID Prefix F0332	Correction	ID Prefix F0428	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.25(m)(1)	Completed	Reg. # 483.60(c)	Completed
LSC	04/27/2016	LSC	04/27/2016	LSC	04/27/2016
ID Prefix F0505	Correction	ID Prefix F0514	Correction	ID Prefix	Correction
Reg. # 483.75(j)(2)(ii)	Completed	Reg. # 483.75(l)(1)	Completed	Reg. #	Completed
LSC	04/27/2016	LSC	04/27/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 05/11/2016	SIGNATURE OF SURVEYOR 35567	DATE 5/3/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/18/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245528 (Y1)	A. Building 01 - MAIN BUILDING B. Wing (Y2)	5/4/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 04/27/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 04/27/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 04/27/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 5/11/2016	SIGNATURE OF SURVEYOR 37008	DATE 5/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/17/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3O28

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245528**

2. STATE VENDOR OR MEDICAID NO. (L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **03/18/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	43			
(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 :
Lisa Carey, HFE NF II 04/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 04/22/2016 (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 **04/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 7, 2016

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

RE: Project Number S5528026 and Complaint Number H5528006

Dear Mr. Samuelson:

On March 18, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 27, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 27, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that

substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 18, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. " A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. " An investigation of complaint H5528006 was completed. The complaint was substantiated. Deficiency(ies) issued at F157 & F309.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157		4/27/16

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

Electronically Signed | 04/14/2016

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

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F 157	Continued From page 1 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician in a timely manner regarding significant changes in health condition post kidney transplant for 1 of 1 resident (R56) who was admited from an acute care hospital following a kidney transplant. The failure to notify the physician regarding significant health changes caused harm, including increased pain and hospitalization for R56. Findings include: R56 was admitted to the facility on 8/27/15 post kidney transplant on 8/13/15. R56 diagnoses identified on the facility face sheet included: pain, chronic pain syndrome, diabetes, nutritional deficiency, hypertension, chronic ischemic heart disease, constipation, osteoporosis with recurrent pathological fractures, and chronic kidney disease.	F 157	Medical provider saw resident 56 in less than 24 hours from admit. Family was at resident bedside throughout the day. Resident and family were involved in the plan of care and in response to his issues. Nursing staff did recognize that pain was unresolved from the interventions that were provided. Further assessment was done and it was noted by staff that the resident may be suffering from a suspected ileus. A decision was made to transfer R56 to an emergency department. The transplant team had been contacted regarding this and he was transferred via ambulance with family in attendance on the second day post admission. He was then discharged from the facility and so he was taken care of	

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F 157	Continued From page 2 R56's hospital discharge summary included, "he was tolerating a general diet, his pain was controlled on oral pain medications, he is able to move with assistance, he had normal bowel function, and was discharged with a foley catheter." The hospital summary included historical abdominal pain levels during therapy sessions on 8/14/15, 8/21/15, 8/24/15, and 8/25/15. The reported pain levels did not exceed five when using a zero to ten (ten-highest pain level) pain rating scale. The summary included instruction to call the transplant coordinator if systolic blood pressure was greater than 180 and diastolic blood pressure greater than 90, temperature over 100.5 fahrenheit, and for increase in pain. The summary indicated acute changes in respiratory status should be treated by applying oxygen and would require contact with the primary care physician as soon as possible (ASAP). At the time of discharge, the hospital discharge summary indicated no concerns with respiratory status, abdomen was soft, non-tender, and non-distended. The summary also explained during the hospital course a computerized tomography (CT) scan showed a possible ileus (bowel stops movement of waste) however signs and symptoms had resolved. Review of R56's record did not reflect an initial pain evaluation at the time of admission. An Admission Observation dated 8/27/15, included two questions pertaining to pain; "How much bodily pain have you had in the last 4 weeks?" and "Is this pain new or chronic?" The evaluation indicated R28 had reported having experienced very severe pain in the last 4 weeks and that the pain was new. The Admission Observation further indicated, R28 had no trouble sleeping at night, had trouble with bladder control and bowel control, had kidney problems, no respiratory	F 157	and there is no further follow-up indicated for this individual. The nursing team of the facility did meet with the medical director within a week of R56s discharge, recognizing that any new admission could be at risk if we did not update our procedures. Following that experience and within one month, the facility instituted a change in the admission process. This updated practice was completed and instituted by September of 2015. To further support the already initiated improvements in the admission process, the developed process will be clearly outlined in policy and procedure format which will help to provide direction and reminders for the process. The updated admission process will also indicate how to notify a provider as the resident's condition may indicate. This will be written, and communicated to the nurses primarily responsible for admission by April 27, 2016. All nurses and TMA staff will receive this same information related to the procedure at the next nursing meeting May 9, 2016. Templates within the electronic health record will also be updated to assist admitting nurses with entering elements of an admission plan of care into the system. The facility will also initiate a systematic retraining for all nursing staff related to standard nursing process such as assessment, response and ***REPORTING*** (as in notification of changes to the provider). This retraining will be comprehensive in scope and will start before April 27, 2016 and will continue at monthly meeting for no less	

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F 157	Continued From page 3 concerns, heart rate was regular, no edema present, had diarrhea, abdomen was soft and non-distended, guarding/tenderness present on right and left lower quadrant, bowel sounds active in all four quadrants. The evaluation futher indicated R56 had a Foley catheter draining clear yellow urine, and no musculoskeletal concerns were noted. R56's physician orders dated 8/27/15 included: Tylenol 325 milligrams (mg) 2 tablets as needed for acute pain. Special instructions: do not take more than 2000 mg in 24 hour period do to kidney transplant. Oxycodone 5 mg. Special instructions: give 2 tabs for pain rated 7 or higher, and 1 tab for less than 7, for pain not relieved by Acetaminophen as needed every four hours. R56's record reflected a physician assistant (PA)-D note with a visit on 8/28/15 (visit time was not recorded) dictated into the medical record on 8/31/15. PA-D's note included: "He continues with pain in the abdomen at the site of incision, for which he has been using oxycodone p.r.n. [as needed]." PA-D remarked, R56 had been eating, blood sugars were stable, continued to have loose stools, no acute distress, heart rate was regular with no murmur, upper abdomen was somewhat distended but soft with active bowel sounds, and no lower extremity edema. The PA-D also noted, "Nursing staff will continue to monitor and will notify of any changes or decompensation in patient condition." 8/27/15 at 11:40 p.m. the medication administration record (MAR) documentation indicated a licensed practical nurse (LPN) had administered oxycodone for the first time since admission for incision site pain rated 8 of 10, no other description of the pain was documented. The MAR indicated non-pharmacological	F 157	than six months. A chart review of the next ten admissions will be initiated within 48 hours of each new admission to assure that the process is being followed and meets the needs of the newly admitted resident. This chart review will be completed by either the Director of Nursing, a Nurse Manager or Quality Nurse. The process will be clarified as needed based on the results of the audit. After ten admissions, intermittent chart reviews will be completed to assure that the process is maintained. Nursing staff will be required to complete the education provided and pass a post-test evaluation of knowledge. Their work will also be reviewed during the previously listed chart review. Feedback for improvement will be provided on a one to one basis as needed. R56 problems were resolved and taken care of by August 28, 2015. The written process for new admissions will be developed by April 27, 2016. The 48 hour chart reviews will be completed throughout the upcoming year. Clinical education will be completed within six months, but may extend throughout the 2016 year if further problems with applied critical thinking on the job are noted--INCLUDING LACK OF PROPER NOTIFICATION OF PROVIDER WHEN INDICATED. *Please note that the statement of deficiency appears to include an error in documentation where the resident in question is R56; however later that number is listed several times as being	

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F 157	Continued From page 4 interventions including provide one to one/distraction, and repositioning had been attempted prior to the oxycodone. The record did not reflect results of the non-pharmacological interventions however, effectiveness of the medication (no time stamp for evaluation of efficacy) was recorded. Even though R56's discharge summary from the hospital included the directive to contact the transplant coordinator for increase in pain, there was no documented evidence the physician or transplant coordinator had been notified regarding R56's change in pain intensity. 8/28/15 at 12:09 p.m. the MAR reflected Tylenol 650 mg had been administered by trained medication aide (TMA)-A for pain rated at a 10 of 10 even though the physician orders indicated use of Oxycodone 5 mg 2 tabs for pain rated 7 or higher. The MAR documentation indicated the pain location was in the resident's back and stomach. There was no documented evidence that non-pharmacological interventions had been utilized, and documentation on the MAR indicated the Tylenol was effective. A corresponding progress note written by TMA-A at 1:53 p.m. included, "He c/o [complained of] pain around incision site. PRN Tylenol was given this afternoon. His [family member-A] stated he gets 'out of it' when he has Oxycodone." There was no documentation to indicate R56's pain rated 10/10 had been assessment by licensed nursing staff and the physician was not contacted. An occupational therapist (OT) note documented by OT-E on 8/28/15 at 3:12 p.m. included: "pt (patient) in severe pain with report of being freezing cold, shivering with increase in SOB (shortness of breath). Nursing notified of symptoms and vitals check, pt has SPO2 (oxygen saturation level) decrease to 87% on room air	F 157	R28. The documentation does not reflect anything that happened to R28 and so no response is provided regarding R28.	

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with increased breathlessness. BP (blood pressure) 167/60, 158/60 2nd reading, manually and 160's/117 with automatic BP cuff initially with suspicious of accuracy of reading. Per PT (physical therapist) minimum assist and standing tolerance limited due to severity of right surgical site pain." The note also indicated, "Exhibits cardio-pulmonary limitations as evidenced by Borg Scale of PE (perceived exertion): 5 severe breathlessness impacting need for fluctuation in SPO2 level on room air with 10 of 10 right sided surgical pain."
The medical record lacked any evidence the physician or transplant coordinator had been notified of the findings documented by OT-E on 8/28/15. However on 8/28/15 at 3:22 p.m. the MAR reflected Oxycodone had been administered by a licensed practical nurse (LPN) for pain rated at 10 of 10. The MAR did not reflect the dosage amount, and the assessment did not identify the location of pain, or any description of the pain. A follow-up pain evaluation indicated the Oxycodone was "somewhat effective."
8/28/15 at 4:25 p.m. a progress note written by director of nursing (DON) included: "Called to resident room by staff because of low oximetry (blood oxygen level), resident shaking, complaining of cold and pain. Because he has had complaint of 10 out of 10 pain earlier, staff had given two more tabs as ordered due to unrelenting discomfort [clarified with DON that no extra stat doses given, administration only at 5:08 a.m. and 3:22 p.m.]. Family had mentioned earlier that he had not done well in hospital when he received pain medication-stating that it "wipes him out." Resident observed in bed with 02 at 2 lpm (liters per minute) per standing order sats now wnl (within normal limits), and when asked to point to where it hurts he vaguely indicates a

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large portion of his abdomen-more so to the right. His abdomen is rounded and tympanic with rushing bowel sounds in upper right, and left upper and lower quadrants. No sounds heard in lower right quadrant. This is surgical site." The DON's note also included, "Resident does have shaking of the arms and some occasional jerking of legs. This could be side effect of narcotic. Will maintain on oxygen at this time due to somnolence. Staff notified that may not be tolerating oxy [oxycodone] and to try Tylenol per family report that this is what was done in the hospital. Plan to monitor and notify the provider if increased symptoms or symptoms do not improve. Warm pack applied to right chest wall and feet for comfort. Repositioned. Requests to stay laying flat and he is able to rest without dyspnea (difficulty breathing) or change in color. RN notified of status and to watch VS."

Despite the documented "unrelenting" discomfort, need for supplemental oxygen, absence of bowel sounds, and jerking of hands and legs thought to be potential medication side effect, the record did not reflect notification to the physician or transplant coordinator. In addition, the record did not reflect evaluation of interventions including application of heat to chest wall and feet to relieve the severe abdominal pain, or when and how the pain was decreased or resolved to a tolerable level.

The MAR for 8/28/15 at 9:45 p.m., reflected an LPN had administered Tylenol 650 mg for body pain. The documentation did not reflect pain intensity, location, description of pain, or attempts to use non-pharmacological interventions prior to the medication. A follow-up evaluation (not time stamped) indicated "not effective." The record did not identify what was done as a result of the pain medication not being effective, or if and when the

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pain was resolved to a tolerable level. There was no information a stronger pain medication was given nor if the physician or transplant coordinator had been contacted to evaluate the current pain management regimen.
On 8/29/15 at 6:44 a.m., LPN-B had documented a summary note for the preceeding night shift worked which included: R56 was awake on and off all night and was given Tylenol instead of Oxycodone for pain "this was partially effective" and "BP was fine and temp was fine." The record did not reflect ongoing monitoring of symptoms or vital sign monitoring as indicated by the DON. The record did not reflect notification to the physician or transplant coordinator for pain symptoms which had not improved.
On 8/29/15 at 11:22 a.m., the MAR reflected a TMA had administered Tylenol 650 for pain. No description or intensity of the pain was evident nor evidence of attempted non-pharmacological interventions. The TMA had documented the Tylenol was "somewhat effective." The record did not reflect whether a licensed staff member had evaluated the pain, evaluated effectiveness of the medications used to treat pain, and/or re-assessed the pain for further interventions.
On 8/29/15 at 2:54 p.m., a corresponding progress note had been written by the TMA who'd administered the tylenol at 11:22 a.m.; "He [R56] c/o pain in his abdominal region. TMA gave him PRN Tylenol 325 mg 2 tabs. Those were somewhat effective.", and "Per family request they don't want him to have Oxy [oxycodone] unless he is in extreme pain at night to help him sleep."
The record still did not reflect communication to the physician, or transplant coordinator, related to the resident's ongoing pain, or possible side affects of the oxycodone, so a stronger pain

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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medication could replace the oxycodone for pain control.
On 8/29/15 at 3:50 p.m., a progress note written by DON included, "Happened to be in the facility, and was notified around 2:30 [p.m.] that resident was vomiting bile colored fluid and had decreased output from foley. Nurse concerned about bowels because distended abdomen continues." The note further indicated the resident had no bowel sounds, nothing to eat since yesterday, dark urine, and pitting +2 pedal edema. The progress note indicated at the time of the assessment R56 had denied pain.
On 8/29/15 at 4:07 p.m., a progress note written by LPN-C included, "resident was vomiting clear to bile fluid continuous since 1400 [2:00 p.m.], his abdomen was distended and I had [DON] come help me with his assessment and she heard no bowel sounds." LPN-C further documented, "He was transported by ambulance at 1545 [3:45 p.m.] [hospital] "
The hospital transplant coordinator was interviewed by phone on 3/17/16 at 12:37 p.m.. She stated "I would have expected them [nursing home staff] to call and to have evaluated the pain somebody should have evaluated the resident, suggestive of an illeus."

During interview with the DON at 1:44 p.m. on 3/18/16, she said that at the time she'd felt the staff just had to monitor and watch the pain. She further explained that R28 hadn't been there long enough to get to know what his pain was. When questioned why staff hadn't contacted the physician for R56 when his pain was over a 7/10, and the pain medication given was not affective in releiving pain, the DON said, "We didn't consider the pain to be a change because we needed to see how he was first." The DON was asked to

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F 157	Continued From page 9 view the initial pain assessment regarding R56's pain. The DON stated there was a problem with the software because the assessment itself was lacking pertinent information regarding pain assessment and control. The DON also stated the nurse should follow up 1/2 hour after pain medications were given to evaluate for effectiveness, and that if a resident was still having pain, the physician should be contacted. A facility policy related to physician notification of change in condition was requested, but was not received.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		4/27/16

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F 225	Continued From page 10 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to thoroughly investigate alleged or suspected abuse and protect the resident from further injury for 3 of 5 residents (R59, R18, R62) reviewed for abuse prohibition. Findings included: LACK OF A THOROUGH INVESTIGATION AND PROTECTING RESIDENT FOLLOWING A REPORT OF ALLEGED PHYSICAL ABUSE: R59's facility face sheet indicated admission to the facility on 5/28/13 with a hospice admission date of 3/13/15. On 5/7/15 an allegation of maltreatment, injuries of unknown origin, was reported to the State Agency (Office of Health Facility Complaints). The initial investigative report included, a "nursing assistant (NA) reported right arm didn't look right. Nurse assessed and arm did not appear to be aligned correctly. Physician notified and states that it could be a possible dislocation of her shoulder. Hospice was notified [R59] is not verbalizing or demonstrating that she is in pain. [R59] is receiving hospice care and appears to be	F 225	At the time of the survey R59 and R62 were both deceased of causes unrelated to the statement of deficiency and no further action can be taken. The care plan for R18 has been updated to include interventions for abuse prevention. Because any resident of a LTC facility is a vulnerable adult and at risk, the Vulnerable Adult Policy related to the investigation and reporting of all alleged or suspected cases of maltreatment including neglect, abuse, injuries of unknown source, or misappropriation of resident property has been updated. This improved policy and procedure includes thorough steps for the investigation process and maintenance of the documentation of investigation. The policy and procedure provides for the protection of residents before, during and after an investigation as well as the implementation of steps to prevent further potential abuse. This policy applies to all	

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F 225	Continued From page 11 at the end stages of the dying process. Verbal response is minimal at this time." On 5/11/15 the facility submitted their final investigative report to the state agency. The report included, "[R59] resided at Gunderson Harmony Care Center since 9/7/11 on memory lane. [R59's] care plan was being followed. Upon Interview with family it was noted that [R59] had a dislocated shoulder was not a new condition." The report also indicated R59 had passed away on 5/10/15. R59's physician's visit notes dated 2/19/15 had a diagnoses of recurrent shoulder dislocation however, was not included on the physical exam or on R59's comprehensive plan of care. R59's facility and hospice progress notes were reviewed from 5/3/15- 5/10/15 and the Progress notes do not reflect right shoulder abnormalities, however did reflect R59 had experienced anxiety and restlessness on 5/4/15. Facility Progress note dated 5/7/15 indicated R59 "was very restless, mumbling and moaning early in shift." The note explained many family members were present at the time, an anti-anxiety medications were administered at 11:20 p.m. and R59 "did finally settle down at about 1:00 a.m." On 3/16/16 the facility was asked to provide all of their investigation and investigation notes used to submit their final findings to the State Agency. At 9:45 licensed social worker (LSW)-A returned with one printed double sided paper with nursing progress notes. Two notes were highlighted. Progress note dated 5/7/15 at 5:40 p.m. included the report of the alleged dislocated shoulder and indicated the family member had reported the R59 had often had a dislocated shoulder for years. Progress note dated 5/8/15 at 9:46 a.m. written by the director of nursing (DON) included,	F 225	persons residing at the Gundersen Harmony Care Center. All staff will receive the policy and initial education on how to implement this policy and procedure on the investigation and reporting of all alleged or suspected cases of maltreatment, neglect abuse, injuries of unknown source or misappropriation of property by April 18 of 2016. To monitor the performance to make sure that solutions are sustained, the Social Worker will assure that the next ten "alleged violations" reports are audited within 2 business days of occurrence. Following this, the Social Worker will assure random audits throughout the next 6 months for no less than 10% of the reports. Feedback and re-education will be provided as needed if problems are noted.	

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"Reviewed and followed up on issue of shoulder. Family feels this is long term condition. May be more apparent to staff due to end of life loss of muscle mass and muscle tone. No incidents have occurred that would have resulted in injury. Staff unaware of any incident that might have disrupted shoulder. No bruising or swelling to indicate acute problem. Continue to provide comfort cares, palliation per hospice plan."

Even though the progress note on 5/8/15 referred to staff interviews, LSW-A indicated the progress notes were the only documentation of the investigation. LSW-A stated we didn't really do an investigation because of what the family had told us about the history when we notified them of the concern. LSW-A stated the physician was notified but did not do a physical examination and indicated R59 was not referred to therapy for an evaluation. In response to the question, how did the dislocation become noticeable on that shift but was not noticeable on the previous shift? LSW-A explained that R59 had steadily lost weight making bony prominences more visible.

During an interview on 3/17/16, at 10:16 a.m. director of nursing (DON) stated she did not recall R59 seeing a physician after the nursing assistant reported the arm out of alignment. Stated she remembered calling family and them stating she had the dislocation for years, stated the physician indicated it was a reoccurring issue. In response to the question, did you talk with any staff as part of the investigation? DON indicated she remembered talking with the person (NA) who reported the concern. DON stated she looked at the shoulder for the first time not clothed and indicated it the dislocation could be seen. DON stated, "I don't remember asking staff if it [arm] was like that before." DON stated we determined the dislocation was not a change in condition, so

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F 225	Continued From page 13	F 225		

we did not investigate it, if the dislocation was new then we would have.
LACK OF REPORTING IMMEDIATELY TO THE STATE AGENCY AND LACK OF A THOROUGH INVESTIGATION AND PROTECTING RESIDENT FOLLOWING AN ALLEGED ABUSE WAS FOUND:
R18's facility face sheet included diagnoses of depressive disorders, dementia with behavioral disturbance, restlessness and agitation, and psychotic disorder with delusions.
R18's 60 day Minimum Data Set (MDS) dated 8/4/15 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6, required extensive assist from one staff member for all activities of daily living except for eating.
R18's skin integrity Event Report indicated a purplish/black bruise measuring 6 centimeters (cm) by 4 cm on the right buttock was discovered on 8/16/15 at 8:30 p.m. The report indicated R18 did not know how the bruise was obtained. The report indicated R18's family member reported a history of skin break down in that area. The report indicated notification to the physician, family, administrator, and the director however, time of notification was not recorded. No staff interviews were evident. The investigation entailed, "[R18] is transferred with assist of two. [R18] had a fractured hip with repair that has not healed correctly and sometimes has trouble transferring and could have bumped the arms of the w/c [wheelchair] when transferring. [R18] denied any maltreatment and none suspected."

R62's annual MDS dated 6/17/15 indicated R62 had moderate cognitive impairment with a BIMS score of 10, required extensive assist from two staff members for bed mobility, transfers, and

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personal hygiene and extensive assist from one staff member for all other activities of daily living. R62's skin integrity Event Report dated 7/2/15 at 1:02 p.m. indicated a 2 cm long open area and a 0.5 cm oval open area inside the right thigh and a 1 cm by 1 cm open area on the back of the left thigh. The report indicated, "[R62] did not know areas were there, so she was unaware how they occurred." The facility interviewed staff member who reported the open areas; the staff member indicated the areas were found during morning cares and the trained medication assistant and nurse manager were notified. The report directed staff to "make sure she doesn't have pants bunched up underneath her as it can rub skin and cause skin breakdown." The event report indicated the physician, administrator, and the DON were notified on the same day at 1:06 p.m. The investigation area of the report was left blank.

This incident lacked a thorough investigation to rule out neglect/abuse/maltreatment.

During an interview on 3/17/16, at 3:00 p.m. licensed social worker (LSW)-A indicated investigations were not completed for these residents because there was no maltreatment suspected based on residents statements of denying maltreatment. LSW-A was asked, how do you differentiate between a cognitively impaired resident not remembering how they obtained the bruise and at the same time remembering they were not mistreated or neglected? LSW-A responded by explaining presence of being around the residents and knowing the residents, "I just know them and know nothing happened." LSW-A then left the conference area where the interview was conducted. The LSW-A returned a short time later and explained after looking at the

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F 225	Continued From page 15 information she understood why a thorough investigation needed to be conducted and understood how the lack of the investigation did not definitively rule out maltreatment or abuse to an outside person reviewing the records. Facility policy Abuse Prevention last revised on 11/8/2012 was reviewed and included: "The Vulnerable Adult Abuse Reporting Act mandates that any employee of a health care facility, who has reason to believe a vulnerable adult is being or has been maltreated, or has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report. The facility also must provide for the voluntary reporting of maltreatment of vulnerable adults, require the investigation of the reports, and provide protective and counseling services in appropriate cases."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to follow the facility policy of Abuse Investigation which directed a thorough investigation of an alleged or suspected abuse and to protect the resident from further abuse for 3 of 5 residents (R59, R18, R62) reviewed for abuse prohibition. Findings included:	F 226	At the time of the survey R59 and R62 were both deceased of causes unrelated to the statement of deficiency and no further action can be taken. The care plan for R18 has been updated to include interventions for abuse prevention. Because any resident of a LTC facility is a vulnerable adult and at risk, the	4/27/16

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F 226	Continued From page 16 LACK OF THOROUGH INVESTIGATION AND RESIDENT PROTECTION UPON LEARNING OF AN ALLEGED PHYSICAL ABUSE: R59's facility face sheet indicated admission to the facility on 5/28/13 with a hospice admission date of 3/13/15. On 5/7/15 an allegation of maltreatment, injuries of unknown origin, was reported to the State Agency. The initial investigative report included, a "nursing assistant (NA) reported right arm didn't look right. Nurse assessed and arm did not appear to be aligned correctly. Physician notified and states that it could be a possible dislocation of her shoulder. Hospice was notified [R59] is not verbalizing or demonstrating that she is in pain. [R59] is receiving hospice care and appears to be at the end stages of the dying process. Verbal response is minimal at this time." On 5/11/15 the facility submitted their final investigative report to the state agency. The report included, "[R59] resided at Gunderson Harmony Care Center since 9/7/11 on memory lane. [R59's] care plan was being followed. Upon Interview with family it was noted that [R59] had a dislocated shoulder was not a new condition." The report also indicated R59 had passed away on 5/10/15. During an interview on 3/17/16, at 10:16 a.m. director of nursing (DON) was asked if they had completed a thorough investigation of possible abuse in regards to R59's unknown cause of dislocated shoulder. In response to the question DON indicated she remembered talking with the person who reported the concern. DON stated she looked at the shoulder for the first time not clothed and indicated it the dislocation could be seen. DON stated, "I don't remember asking staff if it [arm] was like that before. "DON stated we determined the dislocation was not a change	F 226	Vulnerable Adult Policy related to the investigation and reporting of all alleged or suspected cases of maltreatment including neglect, abuse, injuries of unknown source, or misappropriation of resident property has been updated. This improved policy and procedure includes thorough steps for the investigation process and maintenance of the documentation of investigation. The policy and procedure provides for the protection of residents before, during and after an investigation as well as the implementation of steps to prevent further potential abuse. This policy applies to all persons residing at the Gundersen Harmony Care Center. All staff will receive the policy and initial education on how to implement this policy and procedure on the investigation and reporting of all alleged or suspected cases of maltreatment, neglect abuse, injuries of unknown source or misappropriation of property by April 18 of 2016. To monitor the performance to make sure that solutions are sustained, the Social Worker will assure that the next ten "alleged violations" reports are audited within 2 business days of occurrence. Following this, the Social Worker will assure random audits throughout the next 6 months for no less than 10% of the reports. Feedback and re-education will be provided as needed if problems are noted.	

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in condition, so we did not investigate it, if the dislocation was new then we would have.
LACK OF A THOROUGH INVESTIGATION, PROTECTION OF RESIDENT UPON LEARNING OF BRUISING OF UNKNOWN ORIGIN:
R18's facility face sheet included diagnoses of depressive disorders, dementia with behavioral disturbance, restlessness and agitation, and psychotic disorder with delusions.
R18's 60 day Minimum Data Set (MDS) dated 8/4/15 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6, required extensive assist from one staff member for all activities of daily living except for eating.
R18's skin integrity Event Report indicated a purplish/black bruise measuring 6 centimeters (cm) by 4 cm on the right buttock was discovered on 8/16/15 at 8:30 p.m. The report indicated R18 did not know how the bruise was obtained. The report indicated R18's family member reported a history of skin break down in that area. The report indicated notification to the physician, family, administrator, and the director however, time of notification was not recorded. No staff interviews were evident. The investigation entailed, "[R18] is transferred with assist of two. [R18] had a fractured hip with repair that has not healed correctly and sometimes has trouble transferring and could have bumped the arms of the w/c [wheelchair] when transferring. [R18] denied any maltreatment and none suspected."
The incident lacked a thorough investigation to rule out neglect/abuse/maltreatment.

R62's annual MDS dated 6/17/15 indicated R62 had moderate cognitive impairment with a BIMS score of 10, required extensive assist from two

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staff members for bed mobility, transfers, and personal hygiene and extensive assist from one staff member for all other activities of daily living. R62's skin integrity Event Report dated 7/2/15 at 1:02 p.m. indicated a 2 cm long open area and a 0.5 cm oval open area inside the right thigh and a 1 cm by 1 cm open area on the back of the left thigh. The report indicated, "[R62] did not know areas were there, so she was unaware how they occurred." The facility interviewed staff member who reported the open areas; the staff member indicated the areas were found during morning cares and the trained medication assistant and nurse manager were notified. The report directed staff to "make sure she doesn't have pants bunched up underneath her as it can rub skin and cause skin breakdown." The event report indicated the physician, administrator, and the DON were notified on the same day at 1:06 p.m. The investigation area of the report was left blank.
The incident lacked a thorough investigation to rule out neglect/abuse/maltreatment.

During an interview on 3/17/16, at 3:00 p.m. licensed social worker (LSW)-A indicated investigations were not completed for these residents because there was no maltreatment suspected based on residents statements of denying maltreatment. LSW-A was asked, how do you differentiate between a cognitively impaired resident not remembering how they obtained the bruise and at the same time remembering they were not mistreated or neglected? LSW-A responded by explaining presence of being around the residents and knowing the residents, "I just know them and know nothing happened." LSW-A then left the conference area where the interview was

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conducted. The LSW-A returned a short time later and explained after looking at the information she understood why a thorough investigation needed to be conducted and understood how the lack of the investigation did not definitively rule out maltreatment or abuse to an outside person reviewing the records.
Facility policy Abuse Prevention last revised on 11/8/2012 included: "The Vulnerable Adult Abuse Reporting Act mandates that any employee of a health care facility, who has reason to believe a vulnerable adult is being or has been maltreated, or has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report. The facility also must provide for the voluntary reporting of maltreatment of vulnerable adults, require the investigation of the reports, and provide protective and counseling services in appropriate cases."
The policy included the procedure for vulnerable adult reporting:

1. Any staff member witnessing or finding evidence of possible maltreatment will immediately make a report to the charge nurse, i.e. bruising , skin tear, ect.

2. The charge nurse conducts a physical assessment of the resident and seeks medical attention as appropriate.

3. The charge nurse will immediately report the incident to the administrator by calling the administrators cell phone on speed dial at the nurse stations and the directors of nursing. The charge nurse will initiate the appropriate report related to the event and ensure all notifications are made by thoroughly completing the notification section of the required report.

4. When there is immediate suspicion of maltreatment and/or injuries of unknown origin

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GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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F 226	Continued From page 20 the charge nurse will immediately notify the DON or LSW during duty hour or the on call manager during evenings and weekends so an immediate report can be initiated electronically to MDH (Minnesota Department of Health)/OHFC (Office of Health of Health Facility Complaints).	F 226		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		4/27/16

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F 278	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set tool for 1 of 2 residents (R1) reviewed for pressure ulcers; for coding chemotherapy treatments and identify the diagnosis of anxiety for 1 of 6 residents (R42) reviewed for unnecessary medications; for coding accurate eating ability for 1 of 3 residents (R14) reviewed for activities of daily living (ADL) and coding urinary incontinence for 1 of 2 residents (R35) reviewed for urinary incontinence. Findings include: LACK OF ACCURATE CODING OF PRESSURE ULCERS: R1 had a stage 1 and stage 2 pressure ulcer which was not identified on the admission or 30 day MDS assessment, as required. R1's progress note dated 12/6/15, indicated a 3 centimeter (cm) x 3 cm reddened area with some swelling was noted on the left elbow. Foam secured with tape was applied. Positioned arm on a pillow. Encouraged R1 to elevate arm as much as possible on a pillow. R1's admission MDS dated 12/8/15, indicated R1 was at risk for developing pressure ulcers and had no pressure ulcers. The stage one pressure ulcer noted in the nurse progress note dated 12/6/15, was not identified on the admission MDS. R1's progress note dated 12/17/15, indicated a 1 cm by 1 cm blister was noted on elbow. Foam padding was applied.	F 278	For residents numbers 1, 14, and 35 a corrected MDS will be submitted for each miscoded entry by April 27, 2016. For R42, the medication indicated by the survey team as a "chemotherapy medication" is not such a drug. The medication in question was reviewed by the facility nurse manager with the Minnesota Department of Health RAI Coordinator in March and a letter was received from Nadine Olness RN-RAC RAI Coordinator MDH dated March 29, 2016 that the medication is most correctly categorized as "hormone therapy" and may not be submitted as a "chemotherapy agent". We are unable to change any past MDS as this would be incorrect information so no action can be taken at this time. Also for R42, there was no anxiety diagnosis received prior to the beginning of 2016. After chart review, the earliest noted evidence of this diagnosis was February 8, 2016 in the hospital discharge medication list. Prior to that date, R42 was receiving an anti-anxiety medication for the diagnosis of "insomnia" which was reviewed and signed by the medical provider each month. The plan of correction will be to submit a corrected MDS for any previously submitted after the date of February 8 or 2016. We are unable to correct any MDS previous to that date as there was no documentation of such a diagnosis and thus would be a false statement. No other MDSs have been noted with errors since the statement of deficiency	

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F 278	Continued From page 22 R1's progress note dated 12/20/15, indicated R1 had superficial open area to left elbow. Area cleansed and foam padding applied. R1's progress note dated 1/2/16, indicated left elbow open are almost closed. R1's 30 day MDS dated 12/29/15, indicated R1 was at risk for developing pressure ulcers and had no pressure ulcers. The stage two pressure ulcer noted in the nurse progress notes dated 12/17/15, 12/20/15, and 1/2/16, were not identified on the 30 day MDS. On 03/17/2016 at 1:45 p.m., registered nurse (RN)-A stated in Achieve Matrix (the facility electronic record) there was an observation called a focus observation, in which you can select skin weekly. RN-A stated in the weekly skin observation the charge nurse was supposed to do an observation and document measurements of the open area. RN-A stated R1's wound was not being measured on a weekly basis per wound monitoring protocol, on the computer skin focus observations in Achieve Matrix, however nursing progress notes show the area healed. On 03/18/2016 at 1:49 p.m., RN-A verified R1's MDS's had not been completed accurately to reflect the pressure ulcer and stated they have been. LACK OF CODING CHEMOTHERAPY TREATMENTS AND ANXIETY: R42 had a diagnosis of anxiety and received chemotherapy treatment which was not identified on the MDS's, as required. R42's face sheet indicated R42 had diagnoses of anxiety disorder and depressive disorder. R42's nursing home admit physician visit note dated 8/5/15, indicated R42's medications	F 278	has been received, however; it is recognized that due to the complexity of the MDS process, typographical errors and miscoding could happen with any assessment. TO PREVENT FUTURE ERRORS: The facility will continue to use the CASPER report and the MDS Coding Manual to guide the process. What is NEW is that Nurse Managers will make a regular practice of a DOUBLE CHECK against the manual during the coding process AND before submission to be sure that they have coded accurately. If a change is noted from a previous MDS, the nurse will make another check to be sure that this was not a typographical error resulting in a miscoding. FURTHERMORE, Nurse Managers will also notify other staff when they are in process with coding to notify them that they should not be disturbed which will reduce errors. The facility has also initiated a plan for a Nurse Leader to be the "go to" person while Nurse Managers are in the process of coding in order to prevent interruption. Monthly meetings have already been initiated to review the CASPER report to monitor for accuracy in any changes that occur. If a change from a previous MDS is noted, the Nurse Manager will go back and review the information again to be sure that the MDS accurately reflects the resident's most current condition. If an error has been found, a correction of that information will be submitted in a timely manner to CMS.	

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included Anastrozole (chemotherapy medication).
R42's physician orders signed on 3/18/16 included Anastrozole 1 mg by mouth every morning for diagnosis of "unspecified type of carcinoma in situ of unspecified breast [breast cancer]"
R42's 30 day MDS dated 3/7/16, did not identify the anxiety diagnosis and did not identify R42 received chemotherapy.
R42's 14 day MDS dated 2/22/16, did not identify the anxiety diagnosis and did not identify R42 received chemotherapy.
R42's 5 day MDS dated 2/15/16, did not identify the anxiety diagnosis and did not identify R42 received chemotherapy.
R42's quarterly MDS dated 1/22/16, did not identify the anxiety diagnosis and did not identify R42 received chemotherapy.
R42's quarterly MDS dated 11/4/15, did not identify R42 received chemotherapy.
During an interview on 3/17/16, at 3:55 p.m. RN-B stated the physician added R42's diagnosis of anxiety in January 2016 which should have been identified on the MDS's. RN-B also stated failure to identify the chemotherapy was an over-site and indicated it also should have been identified on the MDS.
During an interview on 3/18/16, at 10:39 a.m. the DON stated the facility did not have a policy for coding the MDS, and used the RAI (Resident Assessment Instrument) manual for guidelines on completing the MDS.
Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 include directions to "Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of

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death during the 7-day look-back period." The RAI manual also included directions to "Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item."
LACK OF CODING EATING ABILITY:

R14's quarterly MDS inaccurately reflected R14's eating ability.

R14's quarterly MDS, dated 2/17/16, identified R14 was independent with eating.

R14's Point of Care ADL Category Report, identified for the seven day look back period for the MDS dated 2/17/16, identified R14 had required supervision for eating.

On 3/18/16, at 3:39 p.m. registered nurse (RN)-A stated according to the look back period R14 required supervision for eating. RN-A verified R14's quarterly MDS, dated 2/17/16, was inaccurately coded.

On 3/18/16, at 5:13 p.m., the director of nursing (DON) stated she would expect R14's MDS dated 2/17/16, to be coded as documented.
LACK OF CODING ACCURATE CONTINENCE STATUS:

R35's observation report for bladder, dated 1/20/16, indicated R35 had a history of bladder incontinence, was frequently incontinent and experienced a mix of urge and stress incontinence.

R35's 14 day MDS, dated 2/26/16, indicated R51 was "always continent" of urine.

R35's point of care history (documentation by

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F 278	Continued From page 25 nursing assistants), reviewed from 1/20/16, through 2/26/16, indicated R35 had at least 33 episodes of urinary incontinence. When interviewed on 3/17/16, at 8:32 a.m., nursing assistant (NA)-B stated R35 was incontinent of urine. NA-B stated that R35 would have at least one episode of urinary incontinence a day. When interviewed on 3/17/16 at 8:59 a.m. NA-C stated R35 was incontinent or urine every day. When interviewed on 3/17/16 at 1:21 p.m. NA-E stated R35 was incontinent of urine mostly at night. When interviewed on 3/18/16 at 9:32 a.m. RN-A stated 35's 2/26/16, MDS related to urinary continence was coded in error. RN-A stated R35 was incontinent of urine and a MDS correction would be made to indicate R35 was incontinent of urine. When interviewed on 3/18/16 at 3:14 p.m. the DON stated R35's MDS was wrong and R35's urinary status coding should have been corrected to indicate R35 was incontinent of urine.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		4/27/16

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F 280	Continued From page 26 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: READY FOR REVIEW- EXECEPT NEED R18 FROM CHRISTINA Based on observation, interview and record review the facility failed to revise the care plan to include an intervention implemented after a fall for 2 of 3 residents (R14,34) reviewed for accidents. Based on observation, interview and document review the facility failed to revise the care plan to reflect the current level of assistance required for eating for 1 of 3 residents (R29) reviewed for activities of daily living and failed to revise the care plan to include interventions for diuretic medication for 1 of 6 residents (R18) reviewed for unnecessary medications. In addition, failed to revise the care plan to include nutrional supplments for 1 of 3 residents (R51) reviewed for nutrion. Findings include: R14	F 280	The following corrections have been made for the residents (R) listed: R14-her care plan has been updated to include monitoring and offering assistance for finding items in her closet as she is unlikely to notify staff of when she wishes to look for things out of her reach. R34-The care plan was initially updated at the time of the survey to make sure the call pendant was in place; however, by the next day it was clear that she was unable to understand the use of the pendant of consistently use it to call for help; she removed the pendant and asked for it to be taken away. Her care plan has now been updated for the staff to anticipate her needs and assist as needed. R29-The care plan has been updated to identify the most correct interventions for her eating ability. R51- The care plan is now updated to include the nutritional supplement and the care plan for R 18 is	

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F 280	Continued From page 27 R14's Event Report, dated event 2/15/16, identified interventions/measures to prevent recurrence was monitor as able for resident assistance in finding items in closet. R14's care plan, problem start date of 4/15/16, identified R14 is at risk for all with interventions of calcium as ordered, uses four wheel walker, observe for change in gait, keep call light in reach at all time and R14 requests two one-half side rails up when in bed to assist with turning and repositioning. The care plan failed to include the intervention of monitor as able for resident assistance in finding items in closet. On 3/18/16, at 4:00 p.m., registered nurse (RN)-A verified R14's care plan failed to include the intervention of monitor as able for resident assistance in finding items in closet. On 3/18/16, at 5:13 p.m., the director of nursing stated the intervention should hav been carried over to the care plan for R14. R34 FALLS: R34 had a fall intervention of call pendant which was not added to the care plan. R34 was admitted on 12/2/13, and had a diagnosis of muscle weakness according to facility medical record face sheet. R34 was identified on the quarterly Minimum Data Set (MDS), an assessment dated 1/13/16, to be severely cognitively impaired, required	F 280	updated with an approach related to the use of diuretics, fluid balance and weights. OTHER RESIDENTS AT RISK: It is recognized that all persons within the facility (INCLUDING SIMILAR ISSUES WITH DIURETICS, SUPPLEMENTS, FALLS OR OTHER DISSIMILAR ISSUES) are constantly changing and thus their plan of care must also be fluid and constantly changing to best meet their care needs. HOW WILL THIS BE ADDRESSED: An interdisciplinary team meets in the facility on a weekly basis to review all of the resident's and their current status. In response to the survey, we will make sure all notes from the meeting will be available to staff so they are aware of the discussion and changes that will or have been made in the plan of care. A computer will be available at this interdisciplinary team meeting so care plan changes can be made at the time of the meeting. MONITORING: The interdisciplinary team will be responsible to remind each other during the discussion to add changes to the care plan immediately at the time and monitor each other for compliance on that measure. The notes from the meeting will be posted for all staff to review and staff will be reminded to notify Nurse Managers if they find the care plan does not match the notes provided, OR if they notice a change in condition that requires an update to the Plan of Care. The Nurse Managers and Director of Nursing will	

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F 280	Continued From page 28 limited assist of one staff for transfers, ambulated with supervision of one staff, and had no falls since prior assessment. R34's quarterly fall risk assessment dated 1/14/16, identified R34 was at risk for falls, had intermittent confusion, impaired balance, used devices, received nursing restorative program, and had no falls in past three months. Document review of facility potential for injury event report dated 3/1/16, at 5:15 p.m., revealed R34 was out of the facility with a friend, ambulated with walker, lost balance, and fell onto left side. The report indicated no injury. Document review of facility fall event report dated 3/10/15, at 4:40 p.m., revealed R34 was observed ambulated slowly to the dining room with walker, sat in dining room chair, stood up, squatted, and fell to floor landing on buttocks and then to right side. The report indicated no injury and had large incontinent loose stool. Document review of facility progress notes dated 2/5/16 and 2/9/16 indicated R34 was independent with ambulation and transfers. Progress note dated 2/23/16 indicated R34 was independent with two wheeled walker throughout the facility. Progress note dated 3/3/16, indicated R34 moved about as usual. Progress note dated 3/10/16, revealed a fall in the dining room. Document review of progress notes dated 3/14/15, indicated R34's condition was discussed on rounds and plan to talk with therapy on 3/15/16, regarding recent falls, illness and need for wheelchair.	F 280	likewise have notes from the meeting and are responsible to check that the discussed changes have been documented in the Electronic Health Record. Nurse Managers will also utilize a "Care Plan Auditing Tool" with each MDS submission to make sure the care plan matches the most current assessment data.	

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Document review of progress notes dated 3/15/16, revealed interventions included to refer to physical and occupational therapy, physician notified, instruct R34 not to walk or stand without assistance, and will be given a call pendant (a device worn on body to call for assistance when not near a call light), to alert staff of need for assistance in dining room. Progress notes indicated physical therapy evaluation was completed on 3/15/16.

Document review of R34's care plan dated 3/15/16, revealed two falls in past two weeks, appeared weak and needed more assistance with activities of daily living. Interventions included to check vital signs daily until condition resolved, monitor behaviors and ability to perform activities of daily living, consult provider for other causes for weakness and falls. Interventions directed staff R34 should not walk or transfer without staff assistance, physical therapy and occupational therapy to evaluate and treat, and staff were to provide supervision and cuing during meals.

The care plan did not indicate use of the call pendant as noted in the falls review progress note dated 3/15/16.

Observations on 3/17/16, revealed the following:
7:05 a.m., R34 sat in wheelchair in the dining room near a dining room table. There was no call pendant on R34.
8:00 a.m., R34 was feeding self breakfast with a staff member present. There was no call pendant on R34.
8:30 a.m., R34 was feeding self breakfast with a staff member present. No call pendant on R34.
9:00 a.m., R34 slowly moved wheelchair through the dining room. No call pendant on R34.

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9:15 a.m., R34 was asleep in a recliner in the dining room near the chapel, with feet elevated. No call pendant on R34.

During interview on 3/17/16, at 9:22 a.m., licensed practical nurse-A (LPN-A), verified R34 was in the recliner and had no call pendant. LPN-A stated she did not know if R34 was to have a call pendant but would check.

During interview on 3/17/16, at 9:25 a.m., nursing assistant-B (NA-B) and nursing assistant-C (NA-C) stated R34 did not have a call pendant because did not use the call light and probably would not use a call pendant.

During interview on 3/17/16, at 9:26 a.m., LPN-A verified R34's call pendant was on the night stand in R34's room. LPN-A applied the call pendant at that time.

R34 was observed for 2 hours and 21 minutes without the call pendant in place.

During interview on 3/17/16, at 10:06 a.m., registered nurse-A (RN-A), verified had implemented the call pendant on 3/15/16. RN-A stated R34 had been ambulatory and needed the call pendant because was no longer ambulatory. RN-A stated R34 needed the call pendant to ask for assistance. RN-A verified nursing assistants did not have a care plan or kardex that directed resident care but that they had access to the care plan located in the facility computer system. RN-A stated nursing assistants did not have access to the facility progress notes. RN-A verified the call pendant had not been added to R34's care plan, although other interventions identified on 3/15/16 had been added to the care

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plan. RN-A stated call pendant should have been added to R34's care plan. RN-A stated call pendant had been written in the "huddle book," a staff communication book on 3/15/16.

Document review of facility assessment and care plan protocol policy, undated, revealed the following: Nursing care plan- "We follow the regulations that state a comprehensive care plan is to be developed within seven days. To fill the gap during those seven days, we utilize the physician orders as an initial plan of care related to medications, diet, activity/transfers, special assessments and treatment." Care plan updates- "Care plans are to be updated on a quarterly basis or sooner if a significant change is noted." Expectations of staff following care plans- "We expect that all licensed staff have an understanding that care plans are a standard nursing practice and they should not require special policies that tell them to follow a care plan. This is a matter of licensure and all nurses receive this training." "All CNA (certified nursing assistant) staff receives education upon starting at the facility and throughout their employ that there is a plan of care and the most current plan for the CNA can be accessed via the computer kiosk."

During interview on 3/17/16, at 10:35 a.m., director of nursing stated she would expect the call pendant added to R34 ' s care plan along with the other interventions that were added on 3/15/16.

R29 REVISION OF CARE PLAN FOR ASSISTANCE WITH EATING

Findings Include:

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R29's face sheet revealed R29 was admitted on 7/3/12 with diagnoses of heart failure and chronic kidney disease.

R29 was observed on 03/15/2016 at 11:58 a.m., to be eating her lunch in the dining room using an adaptive plate and silverware, with a staff member sitting by her encouraging her and cueing her to eat.

R29 was observed on 03/17/2016 at 7:27 a.m., to be eating her breakfast in the dining room, using adaptive silverware with a staff member sitting by her encouraging her and cueing her to eat.

The quarterly Minimum Data Set (MDS) dated 11/11/2015, identified R29 required supervision-oversight, encouragement or cueing for eating.

The quarterly MDS dated 2/3/16, identified R29 required extensive assist-resident involved in activity, and staff provide weight-bearing support for eating.

R29's care plan with an approach start date of 9/8/15, indicated, "EATING: Provide set up assistance and orientation to food-may need assist with cutting food--independent with eating. Use clock method to describe where foods are located on her plate." The care plan had not been revised to reflect the change in ADLs with eating.

On 03/18/2016 at 9:11 a.m., nursing assistant (NA)-A stated R29 required a lot of cueing when eating. NA-A stated R29 would usually start out eating pretty well on her own and stated at times R29 was able to eat with just encouragement and

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cueing and other times she would require staff assistance to feed her.

On 03/17/2016 at 10:54 a.m., registered nurse (RN)-A stated R29 has had a decline in her eating abilities. RN-A stated R29 had been moved to a table where a staff member sat for cueing and supervision due to poor intake. RN-A verified that R29's care plan was not current to reflect the decline in eating and stated R29's care plan should have been updated to include R29's abilities fluctuate when eating from needing supervision and cueing to extensive assistance with food and fluids.

A policy and procedure was requested for revision of care plans and was not provided.

R51 NUTRITIONAL SUPPLEMENT:

R51 was admitted to the facility on 11/19/15, with diagnosis of dementia according to resident face sheet.

The facility identified R51 on the quarterly Minimum Data Set (MDS), an assessment dated 2/17/16, to have moderate cognitive impairment and independent eating with set up help.

Document review of R51's nutrition assessment dated 2/16/16, revealed usual weight was 180-190 pounds and weight on 2/8/16, was 182 pounds.

Document review of R51's progress notes dated 3/17/16, revealed R51 ate 100 per cent of meals.

Document review of resident care plan dated

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12/1/15, revealed problem of nutrition, eating 75-100%, admit weight 182#, with approaches that included offer general diet, offer and encourage fluids, record meal and fluid intakes at all meals, and weigh as ordered.

Document review of physician orders dated 12/2/15, revealed orders for weekly weights.

Document review of physician orders dated 3/15/16, revealed orders for ensure at breakfast. There were no orders for diuretic medication that would cause weight loss.

Document review of R51's progress notes revealed the following:
2/29/16,and 3/02/16-R51 not feeling well, emesis.
3/7/16-physician to see for poor appetite.
3/8/16-request re-weight.
3/9/16, 3/12/16, 3/13/16, 3/16/16, and 3/17/16-ate 100% at meals.

During interview on 3/16/16, at 2:00 p.m., certified dietary manager (CDM), verified R51 had recently been ill with gastric intestinal symptoms, had weight loss and started R51 on ensure, a nutritional supplement. CDM stated she expected R51's weight to recover. CDM stated dietary practice was to total liquid intake with each meal, She verified there was no evidence of monitoring supplement intakes.

Observations on 3/17/16, 9:19 a.m., revealed nursing assistant-A (NA-A) ambulated with R51 and walker to the dining room. Observations at 9:50 a.m. revealed R51 sat at the dining room table, already completed egg, toast and cereal, drinking juice at that time. There was no evidence of ensure supplement for breakfast.

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Document review of R51's weight report revealed the following weights in pounds:
11/22/15-185
11/23/15-169.5
11/26/15-179
12/3/15-177
1/7/16-180
1/21/16-171.5
1/28/16-181
2/1/16-187
2/4/16-179
3/3/16-177
3/7/16-162
3/8/16 182.5
3/14/16-166.5
3/17/16-176.5

During interview on 3/17/16, at 1:59 p.m., CDM stated R51's normal weight was 185 pounds. She stated she reviewed weights every Monday and requested re-weights when she saw the weight changes. CDM verified that R51 had lost weight and started R51 on one can of ensure supplement at breakfast beginning on 3/12/16. CDM stated dietary department was to provide the supplement every breakfast. CDM verified there was no documented evidence that R51 received the supplement for breakfast on 3/17/16, or any day since starting the supplement on 3/12/16.

During interview on 3/17/16, at 2:20 p.m., CDM verified R51's re-weight at that time was 176.5 pounds. She stated there was no explanation for why R51's weights fluctuated. CDM stated the scale had been calibrated last 9/2015. She stated staff weigh R51 with clothes off on bath day.

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Document review of facility assessment and care plan protocol policy, undated, revealed the following: Nursing care plan- " We follow the regulations that state a comprehensive care plan is to be developed within seven days. To fill the gap during those seven days, we utilize the physician orders as an initial plan of care related to medications, diet, activity/transfers, special assessments and treatment. " Care plan updates- " Care plans are to be updated on a quarterly basis or sooner if a significant change is noted. " Expectations of staff following care plans- " We expect that all licensed staff have an understanding that care plans are a standard nursing practice and they should not require special policies that tell them to follow a care plan. This is a matter of licensure and all nurses receive this training. " " All CNA (certified nursing assistant) staff receives education upon starting at the facility and throughout their employ that there is a plan of care and the most current plan for the CNA can be accessed via the computer kiosk."

During interview on 3/18/16, at 10:00 a.m., director of nursing verified R51's fluctuating weights since admission. She stated the weight changes were due to using different scales and instructed staff to only use the bath scale. She stated the scales were checked last month and were functional, indicating the problem was the users. Director of nursing verified R51 had been re-weighed several times since admission. Director of nursing verified ensure supplement was not on R51's care plan. She verified there was a physician order for the supplement and she considered physician orders to be part of the care plan.

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R18

R18's Physician Order Report dated 2/17/16 included orders for: furosemide 80 mg twice daily for ischemic heart disease and metolazone 2.5 mg given 1/2 hour before furosemide on Tuesdays and Thursdays for congestive heart failure. Both medications are diuretics [medication to remove excess fluid from the body]. Physician Order Report also included R18 to be on a fluid restriction of no more than two liters per day, to be weighed three times weekly, and to report a weight increase of two to three pounds in one day or five pounds over baseline.

R18's significant change Minimum Data Set dated 2/10/16, revealed severe cognitive impairment.

Review of R18's care plan lacked a problem/goal/approach for the use of diuretic medications, fluid restriction, or obtaining weights.

F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		4/27/16

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F 281	Continued From page 38 by: Based on interview and document review, the facility failed to develop an initial care plan following admission to include necessary interventions which affect the health and comfort for for 5 of 5 residents (R56, R55, R58, R60, R61) who were newly admitted to the facility. Findings included: R56 was admitted to the facility on 8/27/15 for rehabilitation following a kidney transplant on 8/13/15 with diagnoses that included diabetes, nutritional deficiency, chronic pain syndrome, essential hypertension, chronic ischemic heart disease, constipation, osteoporosis, chronic kidney disease, kidney transplant, and retention of urine. R56's admission observation evaluation dated 8/27/15 indicated R56 had severe pain in last 4 weeks, had bladder and kidney problems, used a wheelchair for mobility, had diarrhea, and had an urinary indwelling catheter. R56's initial care plan obtained from the facility's electronic record on 3/17/16. The initial care plan only included; "Is a newly admitted to the facility and requires assistance from staff, resident will be able to negotiate environment without injury and will be able to communicate need to staff. ADL [activities of daily living] needs will be met. May shower no tub baths until cleared by surgeon. Do not immerse incisions until fully healed about 4-6 weeks." The care plan also included assess needs for oral care, provide supplies for denture care or assist with brushing teeth twice per day, dietary needs will be met, notify charge nurse of nay skin irregularities every shift, offer and assist with moisturizer with cares, Resident's emotional needs will be met, and monitor behavioral/mental status. However, R56's initial care plan lacked a plan of	F 281	Correction for the residents (R) listed: R56 was discharged to a hospital in August of 2015 and no further action related to creating an admission care plan can be taken at this time. R55 is no longer a "newly admitted resident" and he now has a comprehensive care plan to cover his active problems. R58 is no longer a "newly admitted resident" and she now has a comprehensive care plan to cover her active problems. R60 is no longer a "newly admitted resident" and he now has a comprehensive care plan to cover his active problems. R61 was discharged to a hospital in August of 2015 and no further action related to creating an admission care plan can be taken at this time. The facility instituted a change in the admission process. This updated practice was completed and instituted by September of 2015. This process includes standard nursing orders for monitoring of comfort, vital signs and resident specific monitoring were initiated. Standing orders from the physician are also available to provide the ability to meet unanticipated resident needs such as the need for oxygen, bowel control and so on. Furthermore, interventions to support the specific needs for admission are added as individualized nursing orders so that all nurses and trained medication aids (TMAs) are aware of how to monitor or intervene. This is considered to be the	

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F 281	Continued From page 39 care for new kidney transplant patient that would include monitoring signs and symptoms of rejection, medication management including monitoring for effectiveness side effects/adverse reactions, monitoring and symptom management for respiratory failure, acute renal failure, hydration/dehydration, and bleeding. R56's initial care plan lacked a plan of care for immunosuppression therapy that would include monitoring and symptom management for signs and symptoms of any kind of infections. R56's initial care plan lacked an individualized plan of care for pain management that would include monitoring, pain location, aggravating, and relieving factors, monitoring and symptom management of medication and medication side effects/adverse reactions, and non-pharmacological interventions. R56's initial care plan lacked an individualized plan of care for insulin-controlled diabetes that would include a plan for monitoring and symptom management of medication and medication side effects/adverse reactions, hypo/hyperglycemia, and diet. R56's initial care plan lacked an individualized plan of care for constipation that included bowel monitoring and management due to having ileus during hospital stay. R56's initial care plan lacked a plan of care for urinary indwelling catheter that would include, device type and management, monitoring for patency, monitoring and symptom management of urinary tract infections. R56's initial care plan lacked specific areas R56 needs assistance with ADLs or how much assistance from staff will be necessary to meet his ADL needs in a safe manner. Although R56's initial care plan addressed skin, the care plan lacked a plan of care for the	F 281	admission plan of care along with a newly developed admission plan of care for the certified nursing assistants (CNAs)who provide direct care. WHAT WILL BE DONE DIFFERENTLY: To further support the already initiated improvements in the admission process, the developed process will be clearly outlined in a NEW policy and procedure format which will help to provide direction and reminders for the process. THE PROCEDURE PORTION WILL OUTLINE HOW TO REVIEW ADMISSION PAPERS, DIAGNOSIS LIST AND PROBLEMS NOTED ON ADMISSION ASSESSMENTS AND HOW TO RESPOND WITH THE PLAN OF CARE. This will be written, and communicated to the nurses primarily responsible for admission by April 27, 2016. All nurses and TMA staff will receive this same information related to the procedure at the next nursing meeting May 9, 2016. ALSO, Templates within the electronic health record WILL BE UPDATED to assist admitting nurses with entering elements of an admission plan of care into the system. THESE TEMPLATES WILL HELP THE ADMITTING NURSE MORE COMPREHENSIVELY OUTLINE THE CARES AND ASSESSMENTS REQUIRED FOR A NEW ADMISSION. PLAN TO MONITOR PERFORMANCE: A chart review of the next ten admissions will be initiated within 48 hours of each new admission to assure that the process is being followed and meets the needs of	

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F 281	Continued From page 40 abdominal surgical incision that would include treatment, routine monitoring for healing, and monitoring for signs and symptoms of infection. R55 was admitted to the facility on 3/8/16, with diagnoses of acute abdominal pain, gastro-esophageal reflux disease, iron deficiency, hypokalemia, major depressive disorder, insomnia, hypertension, history of falling, diabetes, atrial fibrillation, congestive heart failure, hepatic failure and cirrhosis, shortness of breath, nausea, and muscle weakness according to the facility face sheet. R55's admission observation form dated 3/8/16, indicated R55 had severe chronic pain in the last 4 weeks, had problems with bowels, urinary incontinence and fallen in the last month. The observation indicated R55 had balance problems, bleeding problems, heart attack, heart problems, had a pacemaker, high blood pressure, liver problems, memory loss, GI reflux, shortness of breath and had lesions on left and right arms. R55's electronic initial care plan indicated activities of daily living dated 6/4/15, which was prior to the 3/8/16, admission date and lacked support needed to complete all activities of daily living including ambulation, bed mobility, dressing, bathing, toileting and locomotion. In addition, the plan lacked care directives related to the following areas: lacked an individualized plan for pain that would include monitoring, pain location, aggravating, and relieving factors, monitoring and symptom management of medication and medication side effects/adverse reactions, and non-pharmacological interventions; lacked a plan for respiratory status that would include monitoring and symptom management of respiratory distress due to chronic shortness of	F 281	the newly admitted resident. This chart review will be completed by either the Director of Nursing, a Nurse Manager or Quality Nurse. The process will be clarified as needed based on the results of the audit. After ten admissions, intermittent chart reviews will be completed to assure that the process is maintained. The written process for new admissions will be developed by April 27, 2016. The 48 hour chart reviews will be completed throughout the upcoming year.	

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breath; lacked presence of pace maker, monitoring and symptom management of dehydration/fluid volume overload; lacked diabetes and daily use of insulin that would include a plan for monitoring and symptom management of medication and medication side effects/adverse reactions, and hypo/hyperglycemia: lacked an individualized plan of care for risk for falling that would include level of risk and interventions that would prevent or decrease the risk for falls due to history of falling on admission.

R58 was admitted to the facility on 3/9/16. R58's face sheet indicated R58 was diagnosed with cerebral infarction, pain in right shoulder, hypothyroidism, and atrial fibrillation according to the facility face sheet.
R58's admission observation dated 3/9/16, indicated R58 had chronic moderate pain in the last 4 weeks, had heart problems and vision problems.
R58's initial care plan for activities of daily living lacked support needed to complete activities of daily living including, dressing, bathing, locomotion, toileting, and bed mobility.
R58's initial care plan for chronic pain management that would include monitoring, pain location, aggravating, and relieving factors, monitoring and symptom management of medication and medication side effects/adverse reactions, and non-pharmacological interventions.

R60 was admitted to the facility on 3/11/16. R60's face sheet indicated R60 was diagnosed with cerebral infarction, diabetes type II, intellectual disabilities and hypertension.
R60's admission observation indicated R60 was unsteady gait and had weakness.

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R60's initial care plan indicated risk for falls however, the initial care plan lacked safety interventions. The initial care plan failed to include required support needed for ADLs of dressing, locomotion, toileting and bathing. The initial care plan also lacked a plan of care for diabetes that would include a plan for monitoring and symptom management hypo/hyperglycemia, sensory loss, and medication monitoring for effectiveness and side effects/adverse reactions.

R61 did not have an initial care plan developed on admission to the facility in order to direct care. The comprehensive care plan was developed by day 21 of admission.
R61's face sheet indicated R61 was admitted to the facility on 8/27/15, and discharged on 8/29/15.
R61's facility record did not identify any admitting diagnoses.
R61's hospital discharge summary dated 8/27/15, indicated R61 had cardiac quadruple bypass surgery and included wound care. The summary included diagnoses of chronic pain, depression, history of asthma, polyneuropathy, hypertension, and history of falls. Discharge summary identified R61 used Warfarin (anticoagulant medication)
R61's admission observation form indicated R61 had chronic, very severe pain in the last 4 weeks, had depressive symptoms, had a fall within the last month, had heart attack, heart problems, high blood pressure, kidney problems, memory loss, reflux, shortness of breath, and problems sleeping at night. The observation also indicated R61 had weakness, upper extremity one sided weakness, chronic respiratory problems with shortness of breath with activity and at rest, constipation, urinary frequency, had numbness and tingling in all extremities and had swelling and inflammation in left and right upper

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F 281	Continued From page 43 extremities. R61's initial care plan lacked a plan of care that included level of staff assistance needed for ADLs. The initial care plan also lacked a plan of care for respiratory status that would include monitoring and symptom management of respiratory distress and monitoring medication effectiveness and side effects/adverse reactions due to chronic shortness of breath; lacked a plan of care that included wound monitoring and treatment: lacked a plan of care for pain that would include monitoring, pain location, aggravating, and relieving factors, monitoring and symptom management of medication and medication side effects/adverse reactions, and non-pharmacological interventions; lacked an individualized plan of care for risk for falling that would include level of risk and interventions that would prevent or decrease the risk for falling due to history of falls. During an interview on 3/18/16, at 10:41 a.m. the director of nursing (DON) stated the facility was putting order sets for routine monitoring into the physician's orders and using the physician's orders as the initial care plan. However, during an earlier interview at 10:18 a.m. the DON stated direct care staff members did not have access to the physician's order, but did have to the initial care plan. A facility care plan policy was requested and not received.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		4/27/16

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F 282	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a personal safety device was correctly applied and functional as directed by the care plan in order to prevent or minimize the risk for falls for 1 of 3 residents (R28) reviewed for accidents. Findings include: R28's care plan indicated risk for falling related to previous history of falls causing hip fracture, use of narcotic analgesics, intermittent confusion, and incontinence. The care plan directive dated 3/6/16, indicated in capitalized print R28 was to utilized a pressure alarm when in the wheelchair in order to notify staff of attempts to stand unattended. The plan also indicated the alarm did not inhibit R28's movement to prevent her from standing. On 3/14/16, at 6:10 p.m. R28 was observed in alone, own room, seated in her wheelchair. R28 had a personal safety alarm device clipped to left back side of wheelchair, however, the alarm was not plugged into the sensor pad R28 was sitting on rendering the device nonfunctional. Without the alarm plugged in, the device would not sound if R28 attempted self-transfer. R28 stated the alarm device was on her chair because staff did not want her to self-transfer, "They are too protective." During an interview on 3/14/16, at 6:40 p.m. registered nurse (RN)-A confirmed the alarm was not connected to the sensor pad. RN-A connected the alarm and confirmed it was in working order. RN-A stated R28 had an alarm to prevent transfers without assistance and it's use should be identified on the care plan. RN-A stated	F 282	Care was immediately provided for resident 28 when it was noted that the cord was not plugged into the alarm box; this care consisted of plugging the cord of the sensor pad back into the alarm box. OTHERS THAT MAY BE AFFECTED: Any resident where a pressure alarm is utilized may be at similar risk especially if they have the ability and tendency to remove or disengage the alarm as R28 does. WHAT IS BEING DONE TO ENSURE THE PLAN OF CARE IS APPROPRIATELY IMPLEMENTED: A reminder has been provided to staff to remember to review the care plan and/or point of care (POC) documentation screen for notification of which residents utilize a pressure alarm. This information is also available on a hot pink communication sheet posted at the nurses' station for easy reference. The Safe Patient Handling committee will develop an audit tool to monitor for problems related to alarm functionality AND TO SEE THAT STAFF HAVE APPLIED THE ALARMS ACCORDING TO THE PLAN OF CARE. The committee met on April 13, 2016 and the tool will be in use by April 27, 2016. Monitoring will be done every day for five days and then randomly during the week until the Safety Committee next meets. THE AUDIT DOES INCLUDE ANY PERSON WHO HAS ALARM USE LISTED ON THEIR PLAN OF CARE. Any problems found	

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F 282	Continued From page 45 the expectation was for staff to follow the care plan. RN-A stated nursing assistants' should know R28 had an alarm because they had access to her care plan. During the entrance conference on 3/14/16, at 7:00 p.m. director of nursing (DON) stated R28's wheelchair alarm was working earlier because it had sounded when R28 attempted a self-transfer. The DON stated the alarm should have been properly connected to the sensor pad. Policy on care plan implementation was requested and not received.	F 282	during the audit will immediately be addressed and will be communicated to staff for correction INCLUDING ALARM NOT USED WHEN LISTED ON CARE PLAN. The Safety Committee will do a root cause analysis of noted system wide problems and develop a further plan as needed based on those findings.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure a pain assessment had been completed on admission, reassess if pain management was affective to control severe pain for 1 of 1 resident (R56)(closed record review) who was admitted from the acute care hospital following a kidney transplant with acute pain symptoms. As a result of overall lack of pain management and control R56 suffered harm at a G level. In addition, based on document review and	F 309	Medical provider saw resident 56 in less than 24 hours from admit. Family was at resident bedside throughout the day. Resident and family were involved in the plan of care and in response to his issues. Nursing staff did recognize that pain was unresolved from the interventions that were provided. Further assessment was done and it was noted by staff that the resident may be suffering from a suspected ileus. A decision was made to transfer R56 to an emergency	4/27/16

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F 309	Continued From page 46 interview, the facility failed to report weight according to physician's orders for 2 of 6 residents (R42 & R18) who had edema and congestive heart failure. Findings include: LACK OF PAIN ASSESSMENT/REASSESSMENT & ONGOING PAIN MANAGEMENT: R56 was admitted to the facility on 8/27/15 post kidney transplant on 8/13/15, with diagnoses that included pain, chronic pain syndrome, diabetes, nutritional deficiency, hypertension, chronic ischemic heart disease, constipation, osteoporosis with recurrent pathological fractures, and chronic kidney disease according to the facility face sheet. R56's hospital discharge summary included, "Upon discharge, he [R56] was tolerating a general diet, his pain was controlled on oral pain medications, he is able to move with assistance, he had normal bowel function, and was discharged with a foley catheter." The hospital summary included historical abdominal pain levels during therapy sessions on 8/14/15, 8/21/15, 8/24/15, and 8/25/15. The reported pain levels did not exceed five when using a zero to ten (ten-highest pain level) pain rating scale. The summary included instruction to call the transplant coordinator for increase in pain. R56's record did not reflect an initial pain evaluation upon admission nor was there an initial care plan developed before the comprehensive care plan was completed to address pain management needs and interventions. The Admission Observation included two questions pertaining to pain; "How much bodily pain have	F 309	department. The transplant team had been contacted regarding this and he was transferred via ambulance with family in attendance on the second day post admission. He was then discharged from the facility and so he was taken care of and there is no further follow-up indicated for this individual. The nursing team of the facility did meet with the medical director within a week of R56s discharge, recognizing that any new admission could be at risk if we did not update our procedures. Following that experience and within one month, the facility instituted a change in the admission process. This updated practice was completed and instituted by September of 2015. This process includes standard nursing orders for monitoring of comfort, vital signs and resident specific monitoring were initiated. Standing orders from the physician are also available to provide the ability to meet unanticipated resident needs such as the need for oxygen, bowel control and so on. Furthermore, interventions to support the specific needs for admission are added as individualized nursing orders so that all nurses and trained medication aids (TMAs) are aware of how to monitor or intervene. This is considered to be the admission plan of care along with a newly developed admission plan of care for the certified nursing assistants (CNAs)who provide direct care. WHAT WE ARE DOING TO ENSURE RESIDENTS RECEIVE PAIN ASSESSMENTS ETC: To further support the already initiated	

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F 309	Continued From page 47 you had in the last 4 weeks?", and "Is this pain new or chronic?" The evaluation indicated R28 had very severe pain in the last 4 weeks and the pain was new. R56's initial care plan which should be developed on admission and used until the Comprehensive care plan is completed to address pain management needs and interventions. The initial care plan areas that were addressed (activities of daily living, dietary, transfers, and mobility) indicated staff would meet R28's needs however; the plans were incomplete as to how these assessed needs were to be met and not individualized to include level of assistance or need. The initial care plan did identify R28 had an abdominal incision that could not be submerged and to monitor for skin irregularities. R56's physician orders dated 8/27/15 included: · Tylenol 325 milligrams (mg) 2 tablets as needed for acute pain. Special instructions: do not take more than 2000 mg in 24 hour period do to kidney transplant. · Oxycodone 5 mg. Special instructions: give 2 tabs for pain rated 7 or higher and 1 tab for less than 7 for pain not relieved by Acetaminophen as needed every four hours. The pain scale was based on a 0 to 10 rating with 10 being the most excruciating pain possible. R56's record reflected a physician assistant (PA)-D note from a visit on 8/28/15 that was dictated into the medical record on 8/31/15. PA-D reported, "He continues with pain in the abdomen at the site of incision, for which he has been using oxycodone p.r.n. [as needed].", and "Nursing staff will continue to monitor and will notify of any changes or decompensation in patient condition." The following is an outline of R56's reported pain from admission on 8/27/15 through discharge to emergency room on 8/29/15 and the facility's	F 309	improvements in the admission process, the developed process will be clearly outlined in A NEW policy and procedure format which will help to provide direction and reminders for the process-PAIN ASSESSMENT WILL BE INCLUDED IN THIS POLICY/PROCEDURE. This will be written, and communicated to the nurses primarily responsible for admission by April 27, 2016. All nurses and TMA staff will receive this same information related to the procedure at the next nursing meeting May 9, 2016. Templates within the electronic health record will also be updated to assist admitting nurses with entering elements of an admission plan of care into the system INCLUDING PAIN ASSESSMENTS. THE FACILITY WILL UTILIZE THE MDS PROCESS WITH ASSESSMENTS TO CONTINUALLY ADDRESS PAIN CONTROL AND UPDATE CARE PLANS WITH APPROPRIATE PAIN RELIEF MEASURES ON-GOING FOR ALL RESIDENTS. FURTHERMORE, ALL RESIDENTS WILL BE PROTECTED BY THE FOLLOWING: The facility will also initiate a systematic retraining for all nursing staff related to standard nursing process such as assessment, response and reporting-TO INCLUDE PAIN ASSESSMENT. This retraining will be comprehensive in scope and will start before April 27, 2016 and will continue at monthly meeting for no less than six months. NURSES AND TMAs ALREADY RECEIVED EDUCATIONAL	

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F 309	Continued From page 48 response to the pain: 8/27/15 at 3:45 p.m. R56's progress note indicated arrival to the facility between 12:45-1:00 p.m. The progress note did not address pain or mention R56 had pain upon arrival to the facility. 8/27/15 at 5:01 p.m. a progress note indicated potential discharge plan, supportiveness of the family, explanation of the resident's Bill of Rights, and a plan the social worker would visit daily the first week assist with adjustment as needed. 8/27/15 at 11:40 p.m. the medication administration record (MAR) reported a licensed practical nurse (LPN)-C administered Oxycodone for the first time since admission for incision cite pain rated 8 of 10, no other description of the pain was documented. The MAR indicated non-pharmacological interventions of provide one to one/distraction, and repositioning were attempted. The record does not reflect results of the non-pharmacological interventions. However, did indicate effectiveness of the medication (no time stamp for evaluation of efficacy). The record does not reflect physician or transplant coordinator notification for change in pain intensity. Even thought R56's discharge summary from the hospital included the directive to contact the transplant coordinator for increase in pain. 8/28/15 at 2:42 a.m. the MAR indicated three hours after the Oxycodone was administered, LPN-B administered Tylenol 650 mg for pain at the incision cite and was effective (no time stamp for follow-up eval). Documentation did not reflect a pain description, an evaluation of the pain intensity or attempt of non-pharmacological interventions. A corresponding progress note written at 3:34 a.m. summarized the administration of the analgesic administration and effectiveness, without mention of	F 309	REVIEW OF THE IMPORTANCE OF PAIN MONITORING ON APRIL 11. THEY WERE INSTRUCTED IN SCOPE OF PRACTICE, ASSESSMENT VS OBSERVATION AND WHAT WAS MOST APPROPRIATE FOR EACH DISCIPLINE. MONITORING OF PERFORMANCE: A chart review of the next ten admissions will be initiated within 48 hours of each new admission to assure that the process is being followed and meets the needs of the newly admitted resident-INCLUDING PAIN CONTROL. This chart review will be completed by either the Director of Nursing, a Nurse Manager or Quality Nurse. The process will be clarified as needed based on the results of the audit. After ten admissions, intermittent chart reviews will be completed to assure that the process is maintained. NURSE MANAGERS WILL REVIEW CURRENT CHARTS TO BE SURE ALL PERSONS CARE PLANS ARE UPDATED AS APPROPRIATE. Nursing staff will be required to complete the education provided and pass a post-test evaluation of knowledge. Their work will also be reviewed during the previously listed chart review. Feedback for improvement will be provided on a one to one basis as needed. R56 problems were resolved and taken care of by August 28, 2015. The written process for new admissions will be developed by April 27, 2016. The 48 hour chart reviews will be completed throughout the upcoming year. Following this, three charts will be randomly audited per month throughout the year. Clinical	

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F 309	Continued From page 49 non-pharmacological interventions attempted. 8/28/15 at 5:08 a.m. the MAR reflected Oxycodone was administered for back pain rated 4 of 10, however did not include description of the pain. The record does not reflect amount of Oxycodone administered a the time. The MAR indicated non-pharmacological interventions were attempted, however does not indicate effectiveness of the interventions. The MAR indicated the Oxycodone was "somewhat effective" at 9:10 a.m. 4 hours after the Oxycodone dose was given. However, a pain rating was not completed to determine what is meant by "somewhat effective." Documentation reflected the pain evaluation prior to the administration and evaluation for effectiveness was performed by a trained medication assistant (TMA)-A. The record did not reflect a licensed nurse performed a pain assessment or evaluation of the newly reported pain location, or performed a re-assessment of pain when the Oxycodone was only somewhat effective (no other information was provided, i.e. how long the pain lasted or if it was resolved). ***note: In the state of Minnesota only a licensed staff can assess for signs and symptoms of pain and determine what pain intervention is appropriate depending on the severity of the pain as well as other symptoms. This does not include a trained medication aide as they work under the license of the licensed nurse to administer medications. The record does not reflect physician or transplant coordinator had been notified of R56's increased periods of pain, newly reported pain locations, and change in effectiveness of a narcotic pain medication. 8/28/15 at 12:09 p.m. the record does not reflect any pain relieving interventions, monitoring, or	F 309	education will be completed within six months, but may extend throughout the 2016 year if further problems with applied critical thinking on the job are noted. *Please note that the statement of deficiency appears to include an error in documentation where the resident in question is R56; however later that number is listed several times as being R28. The documentation does not reflect anything that happened to R28 and so no response is provided regarding R28.	

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follow-up until 12:09 p.m., seven hours after the Oxycodone was only somewhat effective. Documentation does not indicate how long and how much pain R56 had during that period.
8/28/15 at 12:09 p.m. the MAR reflected Tylenol 650 mg was administered by the TMA-A instead of 10 mg of Oxycodone the physician orders directed to give for pain rated 7 of 10 scale. No description of the pain was evident nor evidence of attempted non-pharmacological interventions. The record indicated the Tylenol was effective (no time stamp on follow-up eval). A corresponding progress note written by the TMA-A at 1:53 p.m. conflicted with the MAR documentation, TMA-A wrote, "He c/o [complained of] pain around incision site. PRN Tylenol was given this afternoon. His [family member-A] stated he gets 'out of it' when he has Oxycodone." The progress note omitted the mention of back pain. The record did not reflect a licensed staff had evaluated the 10/10 pain rating, re-assessment of the incision area that had previously not been causing pain or an evaluation for effectiveness of the Oxycodone.
The record still had not reflected notification to the physician or transplant coordinator for increased severe pain levels rated 10 of 10 or the new location of pain.
3/28/15 at 3:22 p.m. the MAR reflected Oxycodone was administered by an LPN-D for pain rated 10 of 10. The MAR did not reflect dosage amount. The assessment did not identify locations of pain or description of the pain. The record reflected use of non-pharmacological interventions, however did not indicate effectiveness. The follow-up pain evaluation indicated the Oxycodone was again "somewhat effective."
8/28/15 at 5:07 p.m. a corresponding progress

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note written by an RN-B conflicted with the documentation of the LPN-D who gave the Oxycodone. RN-B progress note stated, "Therapy noted [R56] was SOB [short of breath] during therapy. [R56] received 10 mg of Oxycodone at 2:45 for c/o [complaint of] pain. At 4:00 p.m. c/o pain on right side ..."
Occupational therapy note dated 8/28/15 at 3:12 p.m. completed by Occupational therapist-E included, "pt [patient] in severe pain with report of being freezing cold, shivering with increase in SOB. nursing notified of symptoms and vitals check was pt has SPO2 decrease to 87% on room air with increased breathlessness. BP 167/60, 158/60 2nd reading, manually and 160's/117 with automatic BP [blood pressure] cuff initially with suspicious of accuracy of reading. per PT [physical therapy] minimum assist and standing tolerance limited due to severity of right surgical site pain." The note also indicated, "Exhibits cardio-pulmonary limitations as evidenced by Borg Scale of PE: 5 severe breathlessness impacting need for fluctuation in SPO2 level on room air with 10 of 10 right sided surgical pain."
The record still did not reflect the physician or transplant coordinator notification for another complaint by R56 of having severe pain rated 10/10 and now it is located on the right side of body.
8/28/15 at 4:25 p.m. a progress note written by director of nursing (DON) read, "Called to resident room by staff because of low oximetry [blood oxygen level], resident shaking, complaining of cold and pain. Because he has had complaint of 10 out of 10 pain earlier, staff had given two more tabs as ordered due to unrelenting discomfort [clarified with DON that no extra stat doses given, administration only at 5:08

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F 309	Continued From page 52 a.m. and 3:22 p.m.]. Family had mentioned earlier that he had not done well in hospital when he received pain medication-stating that it "wipes him out." Resident observed in bed with 02 at 2 lpm [liters per minute] per standing order sats now wnl [within normal limits], and When asked to point to where it hurts he vaguely indicates a large portion of his abdomen-more so to the right. His abdomen is rounded and tympanic with rushing bowel sounds in upper right, and left upper and lower quadrants. No sounds heard in lower right quadrant. This is surgical site.", and "Resident does have shaking of the arms and some occasional jerking of legs. This could be side effect of narcotic. Will maintain on oxygen at this time due to somnolence. Staff notified that may not be tolerating oxy [oxycodone] and to try Tylenol per family report that this what was done in the hospital. Plan to monitor and notify the provider if increased symptoms or symptoms do not improve. Warm pack applied to right chest wall and feet for comfort. Repositioned. Requests to stay laying flat and he is able to rest without dyspnea [difficulty breathing] or change in color. RN notified of status and to watch VS [vital signs]." Despite the documented "unrelenting" discomfort, need for supplemental oxygen, absence of bowel sounds, and jerking of hands and legs thought to be a medication side effect, the record did not reflect notification to the physician or transplant coordinator. In addition, the record did not reflect evaluation of the interventions of applying heat to chest wall and feet to relieve the severe abdominal pain or when and how the pain was decreased or resolved to a tolerable level. 8/28/15 at 9:54 p.m. the MAR reflected LPN-D administered Tylenol 650 mg for body pain. The documentation did not reflect pain intensity,	F 309		

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locations, description of pain, or attempts of non-pharmacological interventions. The follow-up evaluation (not time stamped) indicated "not effective". The record did not identify what was done as a result of the pain medication not being effective or if and when the pain was resolved to a tolerable level.
8/28/15 at 10:20 p.m. a progress note written by RN-C indicated R56 had a poor appetite that evening so amount of ordered insulin was reduced.
8/29/15 at 6:44 a.m. an LPN-B wrote a summary note for the night shift worked which included: R56 was awake on and off all night and was given Tylenol instead of Oxycodone for pain, "this was partially effective", and "BP [blood pressure] was fine and temp was fine."
The record did not reflect ongoing monitoring of symptoms or vital sign monitoring as indicated by the DON. The record did not reflect notification to the physician or transplant coordinator for pain symptoms not improving.
8/29/15 at 11:22 a.m. the MAR reflected TMA-B administered Tylenol 650 for pain. No description or intensity of the pain was evident nor evidence of attempted non-pharmacological interventions. TMA-B documented Tylenol was "somewhat effective." The record did not reflect a licensed staff member evaluated the pain, evaluated for effectiveness, or re-assessed the pain for further interventions.
8/29/15 at 2:54 p.m. a corresponding progress note written by the TMA-B included, "He [R56] c/o pain in his abdominal region. TMA gave him PRN Tylenol 325 mg 2 tabs. Those were somewhat effective.", and "Per family request they don't want him to have Oxy [oxycodone]unless he is in extreme pain at night to help him sleep."

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Again the record did not reflect communication to the physician or transplant coordinator of the ongoing pain or possible side affects to the oxycodone so a stronger pain medication could replace the oxycodone for pain control especially when the pain is rated at a 5 or more.
8/29/15 at 3:50 p.m. a progress note written by DON included, "Happened to be in the facility, and was notified around 2:30 [p.m.] that resident was vomiting bile colored fluid and had decreased output from foley. Nurse concerned about bowels because of distended abdomen continues." The note further reported, no bowel sounds, nothing to eat since yesterday, dark urine, and pitting +2 pedal edema. The progress note indicated at the time of the assessment R56 denied pain.
8/29/15 at 4:07 p.m. a progress note written by an LPN-E included, "resident was vomiting clear to bile fluid continuous since 1400 [2:00 p.m.], his abdomen was distended and I had [DON] come help me with his assessment and she heard no bowel sounds.", and "He was transported by ambulance at 1545 [3:45 p.m.] [hospital] "
A complaint from the Office of Health Facility Complaints in regards to the care and treatment of R56 read, "[R56] suffered unnecessary excessive pain and suffering while at the care center. Discharge orders from [hospital] clearly state to call the transplant coordinator if [R56] is experiencing a great deal of pain." "While visiting [R56] on August 29th at approximately 2:00 p.m. his condition was alarmingly critical, he was having extreme abdominal pain and he began to projectile vomiting a brown colored bile." FA-A explained once at the hospital R56's stomach was pumped resulting in several liters of bile removed.
During an interview on 3/17/16, at 2:00 p.m. DON

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indicated she was not aware of TMAs scope of practice and stated TMAs were allowed to pass as needed medication without a licensed staff members assessment prior to administration and evaluation of efficacy following the administration. During an interview on 3/18/16, at 1:44 p.m. DON clarified the progress note she had written on 8/28/15; indicated R28 had not received an extra stat dose of Oxycodone, only received the early morning dose then the afternoon dose. DON stated she applied the heat for comfort, DON indicated her progress note was not clear if pain was reduced or resolved related to the use of non-pharmacological interventions, "looked like he got better after a while" stated "family was really after not using Oxycodone." DON indicated she had instructed staff about using non-pharmacological measures in place of the Oxycodone for pain relief. DON stated she would have expected a nurse to do an assessment for pain and discomfort on the evening of 8/28/16. DON stated, was not sure what time R28 was seen by PA-D on 8/28/15 related to diarrhea. In response to the question, "What kind of things would you communicate to the physician?" DON responded, by the time the resident is admitted here they should have clear lung sounds and bowel sounds and all of those things. Also bowel function is not something that we should be monitoring on every shift because there was not a physician's order, he was having loose stools. DON further explained the facility did not have routine order to address vital signs for a week and comfort every shift. DON explained, family reported all that was given for pain in the hospital was Tylenol, again explained family reported R28 got sleepy and was difficult to arouse when taking Oxycodone. DON indicated, at the time she felt that they just had to monitor and watch the pain,

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explained R28 wasn't there long enough for us to get to know what his pain was. We didn't consider the pain to be a change because we needed to see how he was. DON was asked to view the initial pain assessment to find out about his pain. DON read the questions, and indicated a problem with the computer software questions, not enough documentation was completed. DON stated a nurse should be following up 1/2 hour after most pain medication was given to evaluate for effectiveness of the pain medication to lesson pain, and if a resident is still having pain the physician should be contacted.
Facility policy Medications Administration, Documentation, Storage, and Destruction of Medications dated 11/2/15 included, "Medication shall be administered, as prescribed, and in a safe and timely manner." "The facility will utilize the services of Trained Medication Aides (TMA), certified nursing assistant who have completed a college level course that meets the Minnesota state requirements...the TMA may administer PRN medications with approval from the supervising nurse, the TMA may administer narcotic medication with the supervising nurse providing a second signature in the narcotics log." The policy lacks and does not reflect standards of practice for supervising nurse responsibility over the TMA. The policy informed staff, "Medications must be administered in accordance with the orders, including any required time frame. The definition of timely includes administration within the defined interval period or at the specified order time, but will also include an administrative window of one hour before and one hour after such period. The exception to the one hour window is any stat order or any medication that specifies administration relative to another medication or activity that would counter that

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window." "The pharmacy has provided an emergency supply of medications in case a supply of medications is not available. If the emergency supply does not contain the medication needed, a nurse must contact a medical provider to notify then that the ordered medication is not available and to request an alternate order." "All person authorized to administer medications are expected to practice safely and utilize available resources when giving unfamiliar medications or if questions arise regarding stand practice or new procedures. Each nurse's station will have a current medication reference available and nurses may contact the contracted pharmacy for guidance related to medication questions."
Facility policy for pain was requested and not received.

LACK OF REPORTING WEIGHT GAIN AS DIRECTED BY PHYSICIAN:
R42 was admitted to the facility on 8/5/15 with diagnoses that included heart failure and essential hypertension according to the facility Face Sheet.
R42's 30 day Minimum Data Set (MDS) identified the diagnoses of heart failure and hypertension, in addition to use of diuretic medication.
R42's physician's orders included furosemide (diuretic medication) 20 mg every morning for edema; the order indicated a start date of 1/8/16.
Physician's orders also indicated daily weights were ordered on 2/8/15 with instructions to contact the provider if R42 gains 2-3 pounds overnight, gains more than 5 pounds in one week, she feels short of breath or her legs swell (edema).
R42's care plan provided by the facility on 3/18/16 identified the diagnosis of hypertension and

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included interventions of "administer medications per providers orders, monitor condition routinely by wearing ted hose and weekly wts [weights]." However, the care plan lacked a plan of care for heart failure and was not revised to reflect daily weight monitoring per physician orders. In addition, the care plan lacked identification of diuretic use and management and monitoring for dehydration and fluid volume depletion which is a possible side affect from the use of a daily diuretic use to control fluid/edema.

R42's record of daily weights include an overnight weight gain of 6.5 pounds (lbs.) from 128.5 lbs. on 2/24/16 to 135 lbs. on 2/25/16. The weight monitoring also indicated weight gain of 10 lbs from 3/8/16 at 128 lbs. to 138 lbs on 3/12/16. Nurse progress note indicated poor food intake on 3/9 and 3/10. The record lacks identification, evaluation, and physician notification of the weight gains.

R42's treatment administration record (TAR) for February and March 2016 indicated application of thromboembolic deterrent (TED) stockings (helps reduce or prevent edema in lower legs) in the morning and removed in the evening.

R42's nursing progress notes reviewed from 2/8/16 through 3/18/16 lacked monitoring for edema and lacked evaluation of TED stocking use.

Physician progress notes were reviewed for February and March 2016 and had not reflected notification of weight gains of 6.5 and 10 lbs.

During an interview on 3/17/16, at 3:55 p.m. registered nurse (RN)-B stated weights should be monitored by charge nurse and brought to the attention of the case managers. RN-B stated charge nurses should make a progress note indicating weight evaluations.

During an interview on 3/18/16, at 11:00 a.m.

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director of nursing (DON) indicated an issue with following policy and procedure and the complexity of comparing weights in the electronic charting system. DON stated, "It's still the nurses responsibility to know to either notify the physician or give the information to the RN manager. It comes down to reading the instructions."
LACK OF NOTIFICATION OF PHYSICIAN IF WEIGHT GAIN PER PHYSICIANS ORDERS:

R18's Physician Order Report dated 2/17/16 included orders for: furosemide (diuretic) 80 mg twice daily for ischemic heart disease and metolazone (diuretic) 2.5 mg given 1/2 hour before furosemide on Tuesdays and Thursdays for congestive heart failure. Both medications are diuretics [medication to remove excess fluid from the body]. Physician Order Report also included R18 to be on a fluid restriction of no more than two liters per day, to be weighed three times weekly, and to report a weight increase of two to three pounds in one day or five pounds over baseline.

Review of R18's weights obtained from 1/15/16 through 3/16/16 revealed 11 incidents with a weight increase of two or more pounds. Review of R18's progress notes for the same time period lacked any notation of contacting the physician or physician's assistant (PA) of the weight increase.

On 3/17/16 at 10:34 a.m. the director of nursing (DON) stated she was unaware of R18's baseline weight and did not know if the physician had been contacted with weight changes as ordered.

On 3/17/16 at 10:49 a.m. registered nurse (RN)-B, nurse manager, stated, "I can't find a

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F 309	Continued From page 60 baseline weight that is specifically written down. You can't know if he is five pounds over his baseline weight. I can't know if 1/15/16 or 1/29/16 was reported [to the physician]for weight gain. I'm not finding any documentation that is was reported. Usually I'm alerted and I look, don't always get it charted. If it's reported I go look depending if it's a nurse or a TMA [trained medication aide], if he has swelling the PA is alerted."	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive bladder assessment was completed after a significant change in urinary function was identified for 2 of 3 residents (R35, R51); failed to follow interventions that had been initiated to attempt to restore bladder function for 2 of 3 residents (R35, R51) reviewed who had a decline in urinary function and failed to revise the care plan for 1 of 3 residents (R35) reviewed for urinary incontinence.	F 315	In response to the listed deficiencies for the following residents (R), these actions have been taken: The care plan for R35 was immediately updated to better reflect her current incontinence level and interventions are in place to assist her with her incontinence. R51's incontinence issues will be further assessed and his care plan will be updated to reflect his current condition by April 27, 2016	4/27/16

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F 315	Continued From page 61 Findings include: R35 had a decline in urinary incontinence and a comprehensive reassessment was not completed. In addition, R35's care plan was not revised to include the decline in urinary incontinence. R35's face sheet, dated 10/26/15, indicated R35 had a diagnosis of urinary incontinence. R35's admission Minimum Data Set (MDS) dated 11/2/15, indicated R51 was occasionally incontinent of urine and was not on a toileting program. R35's observation report for bladder, dated 11/3/15, indicated R35 had a prior history of bladder incontinence, was occasionally incontinent of urine and experienced leakage due to stress incontinence, experienced incontinence without the sensation of urine loss and experienced incontinence in small amounts. The report indicated interventions in place were use of absorbent products, encouragement of fluids and a toileting schedule and R35 was to be on a toileting schedule which involved toileting upon awakening, prior to meals and after meals. R35's Urinary Incontinence Care Area Assessment (CAA), dated 11/6/15, indicate R35 had urinary urgency required assistance for toileting. R35 had mixed incontinence and had admitted to urinary incontinence at times. The CAA summarized that a care plan would be developed to include the goal of increased independence with toileting.	F 315	Persons with similar problems of dementia or mobility issues are at risk for incontinence. Identification of changes in continence are often noted during quarterly review. To improve on the timeline of noting changes, the CNA staff have already been instructed to document whether an individual is continent or incontinent when documenting voiding. An informal chart review has already shown improvement in this area. This information will be reviewed again at the next CNA meeting in May of 2016 to reinforce the behavior. The Nurse Managers will utilize a Care Plan Audit tool following the MDS period for each resident to determine if urinary problems have been clearly addressed when appropriate. Nurse Managers will also utilize concepts of QAPI to perform a root cause analysis to better determine a plan for improvement related to recognition of changing incontinence and how to better assess and plan for restoration of bladder function as a systematic approach. This will be initiated by April 27, 2016 and will continue as an improvement project this year.	

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R35's 14 day MDS dated 11/9/15, indicated R35 was frequently incontinent of urine.

R35's annual MDS dated 1/20/16, indicated R35 was frequently incontinent of urine and was not on a toileting program.

R35's observation report for bladder dated 1/20/16, indicated R35 had a history of bladder incontinence, was frequently incontinent and experienced a mix of urge and stress incontinence. The report indicated interventions currently being followed were the use of absorbent products, encouraging fluids and a toileting schedule. Added comments indicated R35 was to be on a toileting schedule which included toileting upon awakening, prior to meals and after meals.

R35's care plan, dated 12/17/15, indicated R35 required assistance with activities of daily living (ADL). The plan directed staff to utilize an EZ stand (a machine designed to assist with transferring patients) for transfer to the commode for all toileting needs. Staff were to provide extensive to total assist with hygiene, incontinent product placement and clothing management. The care plan was updated on 12/30/15, and indicated R35 was at risk for pressure ulcers related to occasional incontinence. The plan directed staff to encouraged R35 to drink at least 1,500 cc (milliliters) of fluid daily, keep R35's skin clean and dry as possible by using absorbent, skin-friendly pads/briefs to maintain personal hygiene and dignity.

When interviewed on 3/17/16, at 8:32 a.m. nursing assistant (NA)-B stated R35 was incontinent of urine. NA-B stated R35 would have

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at least one episode of urinary incontinence a day and was able to notify a nursing assistant when she needed to go to the bathroom. NA-B stated if R35 had an incontinent episode, R35 would explain that she just didn't make it to the toilet in time. NA-B stated she tried to assist R35 with toileting every two to three hours and when offered, R35 did not refuse to go to the toilet.

When interviewed on 3/17/16 at 8:59 a.m. NA-C stated R35 was incontinent or urine every day and R35's urinary incontinent had gotten worse since being admitted to the facility. When asked how she knew when to toilet the resident, NA-C explained that the nursing assistants would check on R35 every two hours to see if she wanted to use the toilet and R35 also let staff know when she needed to use the restroom.

When interviewed on 3/17/16 at 1:12 p.m. R35 stated she was usually able to tell when she needed to go to the bathroom but sometimes she would have incontinence without knowing.

When interviewed on 3/17/16 at 1:21 p.m. NA-E stated R35 was incontinent of urine and had more episodes of incontinence during the night shift. NA-E stated during the day, R35 was able to tell the nursing staff when she had to use the bathroom. When asked how the staff knew when to toilet R35, NA-E explained that the staff would ask the resident if she needed to go and the resident would say yes or no.

When interviewed on 3/18/16 at 10:45 a.m. NA-F stated R35 was incontinent of urine and was usually incontinent in the morning. When asked how she knew when to toilet R35, NA-F stated she would assist R35 when she got up in the

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morning. NA-F stated she would check with R35 two hours later to see if she needed to use the restroom and in between those times, R35 would tell someone if she needed to use the restroom. NA-F stated that during the day, R35 was able to notify the staff when she needed to use the restroom and the overnight shift would check R35 and change her as needed.

R35's point of care history, reviewed from 11/1/15, through 3/18/16, indicated R35 was routinely incontinent of urine with episodes of continent urinary voiding.

When interviewed on 3/18/16 at 9:32 a.m. registered nurse (RN)-A stated when R35 had been admitted to the facility she was occasionally incontinent of urine and R35 had stopped letting staff know she had to go to the bathroom. RN-A stated R35 had developed a urinary tract infection (UTI) on 12/21/15. RN-A also stated the facility did not have a specific toileting program developed for R35 and the scheduled toileting program that had been recommended on both urinary observations should have been identified on the care plan. RN-A stated staff should have toileted R35 before and after meals and upon wakening. RN-A stated the physician had not been notified that R35 had worsening in urinary incontinence.

When interviewed on 3/18/16 at 3:14 p.m., the director of nursing (DON) stated R35 should have been on a toileting plan. She stated she assumed R35 did not always call for help like she should when she needed to go to the bathroom.

Review of the document titled, "Assessment and Care Plan Protocol (no date)," it specified that

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basic assessments for the MDS (minimum data set) were to be completed quarterly and as needed but could be done sooner or more often if a resident's condition dictated. It stated that care plans were to be updated on a quarterly basis or sooner if a significant change was noted.

When a policy on urinary assessment was requested, the facility stated that they did not have one.
R51 had a decline in urinary incontinence without a comprehensive bladder assessment and interventions put into place to attempt to restore bladder function.

R51's face sheet indicated R51 was diagnosed with dementia.

R51's admission MDS dated 11/26/15, indicated F51 had moderate cognitive impairment, no behaviors, required extensive assist of one staff for transfers and toileting, was occasionally incontinent of urine and had no toileting program attempted.

R51's care plan dated 2/2/16, indicated R51 had occasional urinary incontinence, R51 liked to be independent with toileting, had resisted cares and directed staff to provide incontinence care after each incontinence episode and assist as able.

R51's quarterly MDS dated 2/17/16, indicated R51 had moderate cognitive impairment, no behaviors, required limited assist of one staff for transfers and toileting, was frequently incontinent of urine and had no toileting program attempted.

R51's quarterly bowel and bladder assessment dated 2/17/16, indicated R51 had frequent urinary

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GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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incontinence, required one staff physical assistance to toilet, had diagnosis of Alzheimer's disease, urge and stress incontinence to directed staff to continue with the current care plan. Although requested, no copy of the assessment was provided.

R51's progress notes dated 3/17/16, indicated R51 required assistance of one staff and a walker to ambulate in hall, was independent with walking in own room and one staff assistance for all other activities of daily living.

R51's physical therapy discharge summary dated 12/17/15, indicated R51 received therapy for muscle weakness. The summary identified R51 received therapy from 11/20/15, to 12/17/15, for standing, problem solving, dressing and toileting. The toileting goal was for R51 to complete toileting with stand by assist, clothing management and to decrease urinary incontinence to two times a day. R51's therapy goal was met on 12/17/15, which indicated R51 was able to complete standby assist transfers from wheelchair to commode/toilet in room, clothing management, staff assistance for perineal care, and nursing reported less urinary incontinence. The discharge note indicated R51 demonstrated overall progress, discharged from therapy due to R51's increase in refusals of therapy and plateau status.

On 3/17/16, the following was observed:
-From 7:05 a.m. until 7:47 a.m. R51 remained asleep in bed. No staff had entered the room.
-At 7:47 a.m. until 7:52 a.m. licensed practical nurse (LPN)-A entered R51's room and administered medications to R51's roommate. R51 remained in bed, asleep. No staff had

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entered the room.
-From 7:52 a.m. until 8:22 a.m. R51 remained in bed, asleep. At 8:22 a.m. LPN-A entered R51's room to administer R51's eye drops and medication.
-At 8:30 a.m. R51 was observed in own room, seated in a wheelchair.
-At 8:43 a.m. remained in room, seated in wheelchair. R51 had appeared to open bathroom door.
-At 8:47 a.m. R51 had wheeled own wheelchair toward the bed.
-At 8:48 a.m. NA-C stated staff assisted R51 with morning cares. NA-C stated R51 was sometimes incontinent of urine.
-At 8:54 a.m. NA-A stated staff provided R51 perineal cares. NA-A stated R51 toileted independently and was not incontinent of urine unless unable to get to the toilet on time.
-At 9:00 a.m. NA-A entered R51's room. R51 was observed sitting on edge of bed with incontinent brief on and attempting to button shirt.
-At 9:03 a.m.-NA-A washed R51's back, applied deodorant, and completed perineal care. NA-A verified R51 was incontinent of small stool and no urine.
-At 9:19 a.m. following the completion of morning cares, NA-A ambulated with R51 and walker to the dining room. R51 was not offered nor assisted to the bathroom.
-9:22 a.m. NA-A verified R51 was not toileted when provided with morning cares. NA-A stated R51 was toileted by NA-C at 8:30 a.m.
-At 9:50 a.m. R51 was observed at the dining room table consuming breakfast.
-At 9:56 a.m.-NA-C stated R51 was toileted between 8:20-8:30 a.m. and had not documented the time R51 was toileted.

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During interview on 3/17/16, at 10:03 a.m. RN-B stated R51 removes incontinent brief and would toilet self independently. RN-B stated she expected nursing assistants to document R51's voiding in the computer system, although they do not document if R51 toilets independently. RN-B verified the most recent voiding documented was a large amount of urine on 3/17/16, at 5:15 a.m.

During interview on 3/18/16, at 10:00 a.m. the DON stated she expected staff to document resident voidings. The DON stated R51 toileted independently. The DON verified the facility bladder assessment dated 2/15/16, identified R51 was frequently incontinent of urine and verified the conclusion that Staff were to continue with R51's current care plan as there was no other plan to attempt to restore R51's bladder function. The DON verified R51's current care plan identified R51 was occasionally incontinent of bladder, liked to be independent, resisted care and directed staff to assist R51 as resident allowed. She stated she would have expected R51's care plan to be updated to include the change in urinary incontinency which was frequently incontinent. The DON verified the facility lacked a voiding diary evaluation to determine R51's voiding routine. The DON stated R51 resisted a voiding program but was unable to provide evidence of any attempts of scheduled toileting plan. The DON verified R51 was seen by occupational therapy for an incontinence program, R51 had improved and was discharged on 12/17/15. She verified the facility identified R51 as occasionally incontinent on the admission MDS dated 11/19/15, and when a decline in bladder function was identified, she would expect staff to determine what the problem was and to monitor for anything that may pertain

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to this, and if nursing assistants charted something different then nurses should have followed up on that. She verified there had been no interventions put into place to attempt to restore R51's bladder function.

Document review of facility assessment and care plan protocol policy, undated, revealed the following: "Furthermore, if the resident's condition requires special assessments not ordered by the physician, we add nursing orders to cover those additional needs specific to what is required by the resident's condition." Further assessments-"We follow the protocol called for by CMS (Centers for Medicare and Medicaid Services) to complete the following on or before the ARD (assessment reference date) date (nurse manager to determine special needs if a particular assessment needs to be done immediately-for instance, a new admit requests to self-administer medications on the first day." Nursing care plan-"We follow the regulations that state a comprehensive care plan is to be developed within seven days. To fill the gap during those seven days, we utilize the physician orders as an initial plan of care related to medications, diet, activity/transfers, special assessments and treatment." Care plan updates-" Care plans are to be updated on a quarterly basis or sooner if a significant change is noted." Expectations of staff following care plans- "We expect that all licensed staff have an understanding that care plans are a standard nursing practice and they should not require special policies that tell them to follow a care plan. This is a matter of licensure and all nurses receive this training. " "All CNA (certified nursing assistant) staff receives education upon starting

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F 315	Continued From page 70 at the facility and throughout their employ that there is a plan of care and the most current plan for the CNA can be accessed via the computer kiosk." Although requested, no bladder assessment policy was provided.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a personal safety device was applied to prevent or decrease the risk for falls and failed to complete a comprehensive evaluation or analysis of the information collected on the fall incident assessment tool for 1 of 3 residents (R28); the facility failed to implement toileting interventions for 1 of 3 residents (R35), and the facility failed to ensure a call pendant was in place for 1 of 3 residents (R34) reviewed for accidents. Findings include: R28's did not have the personal alarm in place to minimize potential injury from falls: R28's annual Minimum Data Set (MDS) dated	F 323	The following actions have already been completed for the following residents(R)in response to the identified problems in the statement of deficiency: R28- the cord from the pressure pad was immediately re-connected to the alarm box. Her family requests the pressure pad alarm unit remain in use despite her ability to remove it, or turn it off. HER CARE PLAN WILL INCLUDE THIS INFORMATION AND TO ANTICIPATE HER NEEDS AND TO MONITOR HER FREQUENTLY WHEN SHE IS NOT IN A PUBLIC AREA AND CAN BE READILY SEEN. R35- Care plan was reviewed and	4/27/16

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F 323	Continued From page 71 3/2/16, indicated moderate cognitive, required extensive assist from one staff member for activities of daily living involving mobility. The MDS further identified R28 to be not steady and required staff assistance to stabilize with transfers, walking, and turning around. The diagnoses included persistent atrial fibrillation, dementia without behavioral disturbance, hypothyroidism, arthritis, and hypertension. R28's care plan intervention dated 3/6/16, included, "PRESSURE ALARM IN WHEELCHAIR to notify staff of attempt to stand unattended. This does not inhibit her movement to prevent her from standing." R28's fall risk assessment with a recorded date of 3/10/16, and a completion date of 3/18/16, indicated a fall risk assessment indicated a high risk for falls with a score of eighteen (assessment indicated anything over a score of ten was a high risk for falls). The fall risk assessment identified factors that would increase the risk for falls that included; imbalance, use of assistive device (wheelchair/walker/cane), intermittent confusion, use of anticoagulants, laxatives, and anti-hypertensives. On 3/14/16, at 6:10 p.m. R28 was observed to be sitting in her wheelchair in room alone. R28 had a personal safety alarm device clipped to left back side of wheelchair; the alarm was not plugged into the sensor pad R28 was sitting on. Without the alarm plugged in, the device would not sound if R28 attempted self-transfer. R28 indicated the alarm was on her chair because staff did not want her to self-transfer, "They are too protective." A Fall Care Area Assessment (CAA) dated	F 323	updated and communicated to staff so that interventions matching her most current needs are taken INCLUDING TOILETING PLAN R34- The care plan was initially updated with the call pendant in place; however, by the next day it was clear that she was unable to understand the use of the pendant or consistently call for help; she removed the pendant and asked for it to be taken away. Her care plan has since been updated for the staff to anticipate her needs ad assist her as needed. All three of these residents have a pressure alarm that will assist in alerting staff if they attempt to get up unassisted/without calling for help. IDENTIFICATION OF OTHERS AT RISK: It is recognized that other persons with similar mobility issues may have similar risk factors and need prevention of FALLS AND injury. PLAN TO PREVENT SIMILAR: A reminder has been provided to staff to remember to review the care plan and/or point of care (POC) documentation screen for notification of which residents utilize a pressure alarm, has a toileting plan or uses a pendant or is unable to use a call device. Information related to mobility and pressure alarms is also available on a hot pink communication sheet posted at the nurses' station for easy reference. PLAN FOR DATA COLLECTION	

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F 323	Continued From page 72 3/15/16, triggered a focus fall care plan related to instability with transfers and receiving antidepressant medication. The CAA identified R28 had a fall with no injury on 3/12/16; the CAA indicated R28 had fallen forward after reaching for something on the floor. The CAA identified potential risk factors and indicated, "Care plan will be reviewed and revised as needed to continue to show risk for falls." During an interview on 3/14/16, at 6:40 p.m. registered nurse (RN)-A confirmed the alarm was not connected to the sensor pad. RN-A connected the alarm and confirmed it was in working order. RN-A stated R28 had an alarm to prevent transfers without assistance. RN-A stated the alarm should be in the care plan. RN-A stated the expectation was for staff to follow the care plan. RN-A stated nursing assistance should know R28 had an alarm because they have access to the care plan. During the entrance conference on 3/14/16, at 7:00 p.m. director of nursing (DON) stated the alarm was working earlier because it had been sounding when the resident attempted a self-transfer. The DON stated the alarm should have been connected to the sensor pad. R35 had numerous falls relating to toileting and a toileting plan was not implemented to minimize the potential of further falls. R35's Face Sheet, dated 10/26/15, indicated diagnoses of low back pain, acute pain due to trauma, urinary tract infection, urinary incontinence, and osteoarthritis of knee. R35's observation report for bladder, dated 11/3/15, indicated the resident had a prior history	F 323	IMPROVEMENT: The forms used for reporting falls, bruises, skin tears etc. are the same forms utilized to address the possibility of a Vulnerable adult situation. The Vulnerable Adult Policy related to the investigation and reporting of all alleged or suspected cases of maltreatment including neglect, abuse, injuries of unknown source, or misappropriation of resident property has been updated. This improved policy and procedure includes thorough steps for the investigation process and DOCUMENTATION/DATA COLLECTION of investigation. The policy and procedure provides for the protection of residents before, during and after an investigation as well as the implementation of steps to prevent further potential incidents. This policy applies to all persons residing at the Gundersen Harmony Care Center. All staff will receive the policy and initial education on how to implement this policy and procedure by April 18 of 2016. NURSING STAFF RESPONSIBLE FOR DOCUMENTATION OF EVENTS SUCH AS FALLS ALREADY RECEIVED EDUCATION RELATED TO THE IMPORTANCE OF ADEQUATE DATA COLLECTION FOR INVESTIGATION PURPOSES AND FOR THE PURPOSE OF CREATING THE BEST CAREPLAN TO MEET THE NEEDS OF OUR RESIDENTS. THIS EDUCATION OCCURRED ON APRIL 11, 2016. NURSING LEADERSHIP ARE ALSO MEETING WITH NURSES ON A ONE TO ONE BASIS TO REVIEW THE	

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F 323	Continued From page 73 of bladder incontinence. The report revealed the resident was occasionally incontinent and stated the resident experienced leakage due to stress incontinence. The resident experienced incontinence without the sensation of urine loss and the resident experienced incontinence in small amounts. The report noted interventions were already in place and included absorbent products, encouragement of fluids and a toileting schedule. The report added R35 was to be on a toileting schedule that read upon awakening, prior to meals and after meals. R35's Potential for Injury Event Report, filed by licensed practical nurse (LPN)-B, dated 12/5/15 at 6:45 a.m., stated, "Res [resident] bathroom call light was sounding. Staff went to see what she needed. They heard her yelling help me. They found res [resident] on her butt on the bathroom floor. They called me to come see her." The event report stated a possible contributing factor which led to the fall was R35's need to use the bathroom. The interventions that were in place at the time of the fall were: chair/bed alarm in place; frequently used items within reach. R35 was interviewed and stated that she had to go to the bathroom and could not wait. The event report contained an excerpt with the heading staff interview which stated that the resident did not call or use her walker or wheelchair; R35 was found on the floor in her bathroom sitting on her butt. The event report concluded with the intervention which stated that R35 was to remind the resident to call for help and wait for staff to come. R35's Progress Notes, dated 1/2/16, at 1:36 p.m., nursing staff reported R35 had self-transferred to the commode during the shift. At that time, no	F 323	DOCUMENTATION FORMS AVAILABLE IN THE ELECTRONIC HEALTH RECORD TO ASSURE THAT THEY ARE ALL COMFORTABLE AND COMPETENT IN THE DOCUMENTATION FORMAT> MONITORING PERFORMANCE To monitor the performance to make sure that solutions are sustained, the Social Worker will assure that the next ten reports are audited within 2 business days of occurrence (THESE REPORTS INCLUDE INFORMATION REGARDING REASONS FOR FALLS SUCH AS TOILETING PLANS, USE OF PENDANTS ETC). Following this, the Social Worker will assure random audits throughout the next 6 months for no less than 10% of the reports. Feedback and re-education will be provided as needed if problems are noted. The Safe Patient Handling committee will develop an audit tool to monitor for problems related to alarm functionality AND PENDANTS IN PLACE. The committee met on April 13, 2016 and the tool will be in use by April 27, 2016. Monitoring will be done every day for five days and then randomly during the week until the Safety Committee next meets. Any problems found during the audit will immediately be addressed and will be communicated to staff. The Safety Committee will do a root cause analysis of noted system wide problems and develop a further plan as needed based on those findings.	

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new interventions had been initiated; nor did the facility evaluate the effectiveness of the interventions previously put in place.

R35's Progress Notes, dated 1/2/16, at 8:29 p.m., nursing staff reported the resident was found with the room door closed and was heading towards the bathroom without having the call light. That occurred twice after the evening meal. The Progress Note stated R35 did not always comply with the request to not get up by herself.

R35's care plan, dated 1/5/16, indicated the resident was at risk for falls due to weakness, dementia and use of psychotropic medications. It identified a goal for R35 to be free from injury. Interventions put in place were to ensure the resident was wearing proper, well-maintained footwear; give R35 verbal reminders not to transfer without assistance; provide an environment free of clutter; keep a call light within reach at all times; bed and chair alarms in place.

R35's observation report for bladder, dated 1/20/16, indicated the resident had a history of bladder incontinence; it stated that the resident was frequently incontinent; the resident experienced a mix of urge and stress incontinence. It specified that interventions currently being followed were absorbent products, encouraging fluids and a toileting schedule. Added comments indicated R35 was to be on a toileting schedule- upon awakening, prior to meals and after meals.

R35's event report, completed by RN-A, dated 3/9/16 at 5:55 a.m., stated R35 was observed falling on her bed and the resident had low back pain. The report stated R35 had attempted to get

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up to go to the bathroom. The report read that possible contributing factors which led to the fall was R35's need to use the bathroom. Interventions in place at the time of the fall were: chair/bed alarm; call light within reach; bed in low position; appropriate footwear. The event report concluded with the intervention that R35 would be kept comfortable so she would not get up again.

R35's progress notes, dated 3/9/16 at 7:28 a.m., nursing staff reported the resident had attempted to self-transfer from her bed to the bathroom. The resident had stated she needed to use the restroom. The personal alarm had been sounding at the time. Staff entered her room and found the resident standing at the end of her bed. When staff arrived, R35 sat on her bed hard, bounced up and then laid down on to the bed. R35 stated she hurt her back again. She rated her pain a 10/10. At that time, R35's interventions that were in place to prevent her from falling were not evaluated to assess the effectiveness.

When interviewed on 3/17/16, at 8:32 a.m., nursing assistant (NA)-B stated the resident had alarms on her wheelchair and bed in order to prevent her from falling. She stated when the event occurred on 3/9/16, the bed alarm did in fact go off which alerted staff that the resident had gotten out of bed. NA-B did not mention any other interventions that were in place.

When interviewed on 3/17/16, at 8:59 a.m., NA-C stated R35 used to stand up to self-transfer. She stated R35 had a bed alarm and a chair alarm in place to prevent falls. NA-C also stated the resident had her bed in low position when lying in bed. NA-C did not mention any other interventions that were in place.

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When interviewed on 3/18/16, at 9:32 a.m., RN-A stated that after the last fall which occurred on 3/9/16, R35 had seen the Physician Assistant (PA)-D on 3/11/16, who had prescribed Olanzapine (an antidepressant) due to overall anxiety. RN-A stated R35's anxiety and behaviors had increased since December 2015. RN-A stated R35 did not have a specific toileting program set up for the resident. RN-A stated the staff should be assisting the resident with toileting before and after meals and upon awakening. When asked what intervention were put in place after event occurred in order to prevent R35 from falling, RN-A stated the resident had alarms in her bed and chair, R35 was to have shoes on, and the resident was to be encouraged to participate in group activity programs. RN-A stated R35 had been in a restorative program but the resident was unable to walk even five feet.

When interviewed on 3/18/16, at 3:14 p.m., the DON stated R35 should have been on a toileting plan. She stated R35 did not always call for help like she should.

Review of the document titled, "Safety Policy and Procedure (6/26/08)," it specified that the care plan should be updated with any safety measures that were to be put in place.
R34 lacked use of call pendant, an intervention put into place after two recent falls:

R34 was admitted on 12/2/13, and had a diagnosis of muscle weakness according to facility medical record Face Sheet.

R34 was identified on the quarterly MDS, dated 1/13/16, to be severely cognitively impaired,

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required limited assist of one staff for transfers, ambulated with supervision of one staff, and had no falls since prior assessment.

R34's quarterly fall risk assessment dated 1/14/16, identified R34 was at risk for falls, had intermittent confusion, impaired balance, used devices, received nursing restorative program, and had no falls in past three months.

Document review of facility Progress Notes dated 2/5/16 and 2/9/16, indicated R34 was independent with ambulation and transfers. The Progress Note dated 2/23/16, indicated R34 was independent with two wheeled walker throughout the facility.

The Progress Note dated 3/3/16, indicated R34 moved about as usual. Progress note dated 3/10/16, revealed a fall in the dining room.

Review of facility Potential for Injury Event Report dated 3/10/16, at 4:40 p.m., revealed R34 was observed ambulated slowly to the dining room with walker, sat in dining room chair, stood up, squatted, and fell to floor landing on buttocks and then to right side. The report indicated no injury.

Review of Progress Notes dated 3/14/16, indicated R34's condition was discussed on rounds and plan to talk with therapy on 3/15/16, regarding recent falls, illness and need for wheelchair.

Review of Progress Notes dated 3/15/16, revealed interventions included to refer to physical and occupational therapy, physician notified, instruct R34 not to walk or stand without assistance, and will be given a call pendant (a

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GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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device worn on body to call for assistance when not near a call light), to alert staff of need for assistance in dining room. The Progress Notes indicated physical therapy evaluation was completed on 3/15/16.

Document review of R34's care plan dated 3/15/16, revealed two falls in past two weeks, appeared weak and needed more assistance with activities of daily living. Interventions included to check vital signs daily until condition resolved, monitor behaviors and ability to perform activities of daily living, consult provider for other causes for weakness and falls. Interventions directed staff R34 should not walk or transfer without staff assistance, physical therapy and occupational therapy to evaluate and treat, and staff were to provide supervision and cuing during meals.

The care plan did not indicate use of the call pendant as noted in the falls review progress note dated 3/15/16.

Observations on 3/17/16, revealed the following: 7:05 a.m., R34 sat in wheelchair in the dining room near a dining room table. There was no call pendant on R34. 8:00 a.m., R34 was feeding herself breakfast with a staff member present. There was no call pendant on R34. 8:30 a.m., R34 was feeding herself breakfast with a staff member present. No call pendant on R34. 9:00 a.m., R34 slowly moved wheelchair through the dining room. No call pendant on R34. 9:15 a.m., R34 was asleep in a recliner in the dining room near the chapel, with feet elevated. No call pendant on R34.

During interview on 3/17/16, at 9:22 a.m., LPN-A, verified R34 was in the recliner and had no call

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pendant. LPN-A stated she did not know if R34 was to have a call pendant but would check.

During interview on 3/17/16, at 9:25 a.m., NA-B and NA-C stated R34 did not have a call pendant because she did not use the call light and probably would not use a call pendant.

During interview on 3/17/16, at 9:26 a.m., LPN-A verified R34's call pendant was on the night stand in R34's room. LPN-A applied the call pendant at that time.

R34 was observed for two hours and 21 minutes without the call pendant in place.

During observations on 3/17/16, at 9:50 a.m., R34 was asleep in a recliner in the dining room with feet elevated and call pendant in place around R34's neck.

During interview on 3/17/16, at 10:06 a.m., RN-A, verified had implemented the call pendant on 3/15/16. RN-A stated R34 had been ambulatory and needed the call pendant because was no longer ambulatory. RN-A stated R34 needed the call pendant to ask for assistance. RN-A verified nursing assistants did not have a care plan or Kardex that directed resident care but that they had access to the care plan located in the facility computer system. RN-A stated nursing assistants did not have access to the facility progress notes. RN-A verified the call pendant had not been added to R34's care plan, although other interventions identified on 3/15/16 had been added to the care plan. RN-A stated call pendant should have been added to R34's care plan. RN-A stated call pendant had been written in the "huddle book," a staff communication book on

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F 323	Continued From page 80 3/15/16. Document review of facility safety policy & procedure accident & incident policy dated 6/26/08, revealed the following: Purpose: "1. To assist in prevention of falls and enhance quality of life for all residents." And " 4. Update the care plan with any safety measures put into place, "such as alarm system or mat. During interview on 3/17/16, at 10:35 a.m., DON stated she would expect the call pendant implemented along with the other interventions that were added on 3/15/16.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		4/27/16

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F 329	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on document review, and interview the facility failed to complete a comprehensive sleep assessment and analysis to justify the use of a sleep medication for 1 of 6 residents (R39) reviewed for unnecessary medications. . Findings include: R39 LACK OF COMPREHENSIVE SLEEP ASSESSMENT AND ANALYSIS TO JUSTIFY THE USE OF A SLEEP MEDICATION: R39's face sheet revealed R39 was admitted on 2/4/15 with diagnoses of dementia with behavioral disturbance and depressive disorder. The significant change in status Minimum Data Assessment (MDS) dated 2-3-16, indicated R39 did not display behavior problems and did not have difficulty sleeping, feeling tired or having little energy. R39's signed physician orders dated 3/15/16 included Trazodone (antidepressant also used as a hypnotic) 50 milligrams (mg) by mouth daily for insomnia and melatonin (hypnotic) 3 mg, 2 tabs by mouth, give at suppertime 5-6 p.m., once an evening. R39's medical record lacked comprehensive sleep assessments and analysis of sleep monitoring to initiate and continue the use of Trazadone and melatonin and none were provided when requested of staff.	F 329	Resident 39 has documentation that clearly supports the need for medications related to sleep, he has been seen by a provider and evaluated for the need of sleep medication and this need for sleep medication has been reviewed on a monthly basis by the consulting pharmacist and the psychotropic medication review committee within the facility. This individual is also a hospice patient where the overall goal is comfort in the end-of-life. The hospice team has been in agreement with the plan of care and the use of the medications for sleep. On-going periodic monitoring of resident's sleep does occur. His care plan will be reviewed and updated as needed to show this as a plan by April 27, 2016. TO IDENTIFY AND PROTECT OTHERS: To reduce any risk to other persons, the psychotropic monitoring committee will review sleep assessment tools and define a process for utilization of such a tool for persons requiring the use of a sleep medication. This committee does identify ALL persons taking any psychotropic medications or sedative type medications. WHEN THE SLEEP ASSESSMENT TOOL HAS BEEN CHOSEN IT WILL BE PUT INTO PLACE FOR USE WITH ANY	

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F 329	Continued From page 82 R39's care plan did not include insomnia or address non-pharmacological interventions for sleep. On 03/18/2016 at 10:22 a.m., registered nurse (RN)-A stated the facility had no formal comprehensive sleep assessment. RN-A stated all psychotropic medications including medications used for sleep/insomnia, were discussed on a monthly basis with the director of nursing, nurse managers, pharmacy consultant and social worker. RN-A stated sleep pattern was monitored per the nursing order through behavior tracking periodically each month. RN-A stated there was no documented analysis of the sleep pattern completed. RN-A stated R39 did not have a care plan developed for sleep. RN-A stated R39 should have a sleep assessment, care plan and non-pharmacological interventions in place for sleep. RN-A stated sleep assessments were not being completed in the facility and stated a formal sleep assessment tool will be developed for use. On 03/18/2016 at 11:25 a.m. the director of nursing (DON) stated sleep monitoring goes onto the behavior sheets and was completed for one week of the month and was reviewed at the monthly psychotropic meeting. The DON stated reviewing the sleep pattern was not a comprehensive sleep assessment. The DON stated a sleep assessment should be completed when a resident comes in on a medication for sleep, when there is a change in sleep medication dose or when we are starting a medication to help with sleep. The DON stated a sleep care plan should be completed for resident on sleep medications and was to include non-pharmacological interventions to help promote	F 329	PERSON TAKING THESE MEDS OR PRIOR TO THEIR USE AS THE CASE MAY BE TO MONITOR: THE PSYCHOTROPIC MONITORING COMMITTEE WILL REVIEW EACH PERSON USING SUCH MEDICATIONS ON A MONTHLY BASIS AS ALWAYS, BUT WILL NOW INCLUDE MAKING SURE THE SLEEP ASSESSMENT HAS BEEN UTILIZED. THIS PROCESS WILL BE ON-GOING.	

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F 329	Continued From page 83 sleep. A policy and procedure was requested for comprehensive sleep assessment and development of a resident care plan and were not provided.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all medications were administered in a timely fashion in accordance with physician orders and facility practice for 2 of 5 residents (R15, R18) reviewed for medication administration. This resulted in a medication error rate of 12 percent. Findings include: R15 was administered scheduled medication on 3/17/16 at 8:27 a.m. by licensed practical nurse (LPN)-A. LPN-A was observed to administer Miralax (bowel medication) 17 grams mixed in 4 ounces of orange juice, at 8:32 a.m. instilled Azopt drops into both eyes, and at 8:35 a.m. instilled one drop of Systane drops in both eyes. (Azpot and Systane eye drops are used to treat glaucoma.) R15's physician orders dated 2/17/16 read;	F 332	The following corrections have occurred for Resident 15. The nurse administering medications has been educated in the correct amount of fluid to mix with the Miralax to match the pharmacy label and MAR directions. The product label does state that any amount from 4 to 8 ounces may be utilized; however, the nurse understands that the current order should be followed. The orders within the electronic medication record (EMAR) for the Azopt and Systane drops have been adjusted to better define the time between drops and prevent future errors. The provider was given an update regarding the medication errors and no concerns were noted from provider. For resident R18 the EMAR was also adjusted to better divide the doses between the two medications indicated. Previously, both medications did show up as due at the same time despite written	4/27/16

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F 332	Continued From page 84 "Miralax Powder 17 gram/dose twice a day" with label instructions to mix with 8 ounces of fluid; "Azopt eye drops 1 drop to both eyes give 30 minutes apart from other eye drops, and Systane eye drops 1 drop in left eye four times a day." Review of R15's Medication Adminstation History; R15's morning dose of Azopt eye drops were administered incorrectly for the past 31 out of 32 opportunities; administering the Azopt eye drops with the Systane eye drops. R18's Physician Order Report dated 2/17/16 included orders for: furosemide 80 mg twice daily for ischemic heart disease and metolazone 2.5 mg given 1/2 hour before furosemide on Tuesdays and Thursdays for congestive heart failure. Both medications are diuretics [medication to remove excess fluid from the body]. Physician Order Report also included R18 to be on a fluid restriction of no more than two liters per day, to be weighed three times weekly, and to report a weight increase of two to three pounds in one day or five pounds over baseline. R18's medication administration record (MAR) included the order the metolazone with special instructions, "given 1/2 hour before his lasix." R18's Medication Adminstation History revealed from 2/4/16 through 3/17/16; metolazone was administered incorrectly 12 of 13 opportunities. Metolazone was incorrectly administered with furosemide. On 3/17/16 at 7:54 a.m. licensed practical nurse (LPN)-A stated she gave R17 all of his morning medications together, including furosemide & metolazone. "That would be a medication error.	F 332	direction to give 30 minutes apart. The provider was notified of the error and the adjustments made. To further reduce problems with the Miralax that might occur for any other resident, 8 ounce paper cups were immediately purchased and all 6 ounce cups removed from the medication carts. A medication error reduction committee had already been formed prior to the survey date and this committee will begin meeting on a regular basis to follow QAPI guidelines in developing interventions to reduce future errors. A nursing/TMA meeting was held on April 11, 2016 to initiate retraining on nursing skills and proper steps of medication administration reminders were given at that time. A follow up meeting will occur May 9, 2016 for further review on medication administration. Nurses/TMAs will be required to pass a written examination related to the basic skills of medication administration. The Director of Nursing has already developed a plan to meet monthly with the Medical Director and the review of trends in medication errors will take place during those meetings	

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The medication is only given twice a week." LPN-A added she was unaware why the metolazone needed to be given prior to the administration of furosemide.

On 3/17/16 at 9:48 a.m. and 10:34 a.m. the director of nursing (DON) stated, "My expectation to follow the MAR, she [LPN-A] told me she got shook and forgot her process, they are to follow the MAR and do their 3 checks." The DON verified the eye drops were administered incorrectly. DON said, "I see what you mean about the metalozone and furosemide given together and you are right [to the comment about not giving both diuretics at the same time]. I know it doesn't change anything now but I will put in a time stop for it to be given 30 minutes before the furosemide. I think they would see the color block [on the Medication Administration Record] and not give it together."

On 3/21/16 at 10:28 a.m. the facility pharmacy's pharmacist-B stated that Miralax dissolves most effectively in 1 cup [8 ounces] of fluids. The pharmacist added that Azopt eye drops could be washed out by another eye drop if another eye drop was administered within 10 minutes of Azopt, making Azopt not effective and not absorbed by the eye. The pharmacist added, regarding metalozone, "It tends to be absorbed better on an empty stomach and not given with anything [other medications] else."

Facility policy, Medication Administration, Documentation, Storage, and Destruction dated 11/2/15 reads: "4. Medications must be administered in accordance with the orders, including any required time frame."

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F 428	Continued From page 86	F 428		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the consulting pharmacist identified the lack of a comprehensive sleep assessment and analysis to justify the use of a hypnotic medication for 1 of 6 resident (R39) reviewed for unnecessary medications. Findings include: R39 LACK OF COMPREHENSIVE SLEEP ASSESSMENT AND ANALYSIS TO JUSTIFY THE USE OF A SLEEP MEDICATION: R39's pharmacy monthly regimen reviews revealed the consulting pharmacist did not identify the lack of a comprehensive sleep assessment and documented analysis of sleep monitoring to justify the initiation and ongoing use for the Trazadone (an antidepressant used for sleep) and melatonin (a supplement used for sleep). R39's face sheet revealed R39 was admitted on 2/4/15 with diagnoses of dementia with behavioral disturbance and depressive disorder. The	F 428	Resident 39 has documentation that clearly supports the need for medications related to sleep, he has been seen by a provider and evaluated for the need of sleep medication and this need for sleep medication has been reviewed on a monthly basis by the consulting pharmacist and the psychotropic medication review committee within the facility. This individual is also a hospice patient where the overall goal is comfort in the end-of-life. The hospice team has been in agreement with the plan of care and the use of the medications for sleep. On-going periodic monitoring of resident's sleep does occur. His care plan will be reviewed and updated as needed to show this as a plan by April 27, 2016. To reduce any risk to other persons, the psychotropic monitoring committee will review sleep assessment tools and define a process for utilization of such a tool for	4/27/16

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F 428	Continued From page 87 significant change in status Minimum Data Assessment (MDS) dated 2-3-16, indicated R39 did not display behavior problems and did not have difficulty sleeping, feeling tired or having little energy. R39's signed physician orders dated 3/15/16 included Trazodone 50 milligrams (mg) by mouth daily for insomnia and melatonin 3 mg, 2 tabs by mouth, give at suppertime 5-6 pm, once an evening. R39's medical record lacked comprehensive sleep assessments and analysis of sleep monitoring to initiate and continue the use of Trazadone and melatonin and none were provided when requested of staff. R39's care plan did not include insomnia or address non-pharmacological interventions for sleep. On 03/18/2016 at 10:22 a.m., registered nurse (RN)-A stated the facility had no formal comprehensive sleep assessment. RN-A stated all psychotropic medications including medications used for sleep/insomnia, were discussed on a monthly basis with the director of nursing, nurse managers, pharmacy consultant and social worker. RN-A stated sleep pattern was monitored per the nursing order through behavior tracking periodically each month. RN-A stated there was no documented analysis of the sleep pattern completed. RN-A stated R39 did not have a care plan developed for sleep. RN-A stated R39 should have a sleep assessment, care plan and non-pharmacological interventions in place for sleep. RN-A stated sleep assessments were not being completed in the facility and stated a formal	F 428	persons requiring the use of a sleep medication. The consulting pharmacist is a leading member of this committee. The pharmacist will add "assessments needed" to his recommendations as they may apply going forward. HE WILL BE NOTIFIED IMMEDIATELY	

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F 428	Continued From page 88 sleep assessment tool will be developed for use. On 03/18/2016 at 11:25 a.m. the director of nursing (DON) stated sleep monitoring goes onto the behavior sheets and was completed for one week of the month and was reviewed at the monthly psychotropic meeting. The DON stated reviewing the sleep pattern was not a comprehensive sleep assessment. The DON stated a sleep assessment should be completed when a resident comes in on a medication for sleep, when there is a change in sleep medication dose or when we are starting a medication to help with sleep. The DON stated a sleep care plan should be completed for resident on sleep medications and was to include non-pharmacological interventions to help promote sleep. On 03/18/2016 at 5:32 p.m., the consultant pharmacist stated he expected sleep assessments to be completed for residents that receive sleep medications. The Medication Prescribing, Utilization and Oversight policy dated 1/24/14 included, "...The facility will contract with a consulting pharmacist who will review every residents medical regime, medication orders, ,medication utilization, associated lab orders, symptoms, behaviors,contraindications and so on, each month..."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		4/27/16

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F 441	Continued From page 89 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure inhalation nebulizer equipment was cleaned and stored appropriately to	F 441	To reduce the risk of infection for all three resident listed, 2& 29, the nebulizer supplies were immediately disposed of	

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	245528	A. BUILDING _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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F 441	Continued From page 90 decrease/prevent the risk of infection for 3 of 3 residents (R2, R10, R29) observed to have nebulizers. Findings include: R2's room was checked during the initial tour on 3/14/16, at 6:10 p.m. R2's nebulizer machine was sitting on reclining chair. The medication reservoir was 1/8th full of clear liquid with moisture in the tubing. R2 was not in the room at the time. R2's Physician Orders included, Ipratropium-Albuterol solution by nebulizer: 0.5 mg (milligrams)-3 mg/3 ml (milliliters) one vial inhalation. Administer at 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m. and twice per day as needed for cough/dyspnea/wheezing. R10's room was checked during the initial tour on 3/14/16, at 6:10 p.m. R10's nebulizer machine was sitting on the counter by the window. The medication reservoir chamber was ¼ full of clear liquid, with moisture in the tubing. The reservoir chamber was laying on its side breathing mask was face down on the counter, touching the counter surfaces. R10's Physician Orders did not reflect an order for a nebulizer medication. R29's room was checked during the initial tour on 3/14/16, at 6:10 p.m. R29's nebulizer machine was sitting on the counter by the window. The medication reservoir chamber was completely full of clear liquid and laying on its side so the mouthpieces were touching the counter top surface. R29's Physician Orders included, Ipratropium-Albuterol solution by nebulizer: 0.5 mg -3 mg/3 ml one vial inhalation. "Administer	F 441	and fresh units used. The TMA and nurse on staff at the time received immediate education on infection control and cleaning/storage of the nebulizer equipment. Although the surveyors Statement of Deficiency includes R10, the resident list provided to the facility does not indicate any of the residents as being assigned the number R10. We are unable to respond to R10. To avoid any risk to other residents who may be utilizing nebulizer treatments, a written reminder of the appropriate care, cleaning and storage of the equipment will be provided to all individuals who may be involved in such administration of medication by April 27, 2016. This will be followed with further reinforcement of the information at a nursing/TMA meeting May 9. 2016 where standard medication administration practices will be reviewed. MONITORING: RANDOM AUDITS OF THE SUPPLIES AND EQUIPMENT WILL BE DONE BY NURSING LEADERSHIP OR DELEGATED PERSONS EACH WEEK FOR TWO MONTHS. FURTHER EDUCATION WILL BE PROVIDED IF PROBLEMS ARE FOUND	

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F 441	Continued From page 91	F 441		

three times a day in morning, noon, at before bed and may have every four hours as needed for wheezing."

During an interview on 3/14/16, at 6:40 p.m. registered nurse (RN)-A confirmed the nebulizer machine components were stored incorrectly for R2 and R29. RN-A stated medication should not be left in residents rooms, stated the reservoirs should be cleaned out, left to air dry, and then put away. Stated R29's nebulizer solution should be changed out prior to administration because of possible contamination and R2's equipment needed to be either changed or disinfected. RN-A stated the expectation was the medication not be set up and left in the room, and equipment was cleaned and stored appropriately after each use.

During an interview on 3/14/16, at 6:45 p.m. RN-B confirmed nebulizer machine components were stored incorrectly for R10. RN-B stated the reservoir and mask should have been cleaned, left out to air dry, and then put away.

The Manufacturer's instructions for the nebulizer machine and components included instruction on cleaning, disinfecting, and sterilizing the nebulizer components and accessories. Instructions directed staff to:

1) Disconnect the tubing from the compressor and from the bottom of the nebulizer cup.
2) If there is any moisture in the tubing, let the compressor run with tubing only 2-3 minutes or dry the tubing by removing it from the compressor and hanging up with the ends down to allow the moisture or to drain out. Use a clean damp cloth to wipe exterior of the machine.
3) Disassemble tubing and accessories

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F 441	Continued From page 92 4) Wash all parts with warm water and liquid dish soap and don't wash the tubing. 5) Rinse thoroughly with warm water and shake out water 6) Air dry or hand dry nebulizer parts on a clean, lint free cloth. Reassemble nebulizer parts when parts are dry and store. The instructions directed staff to disinfectant and sterilize the equipment for one hour every other treatment day using one distilled vinegar to three parts hot tap water and store as above. Facility policy Medication Administration, Documentation, Storage, and Destruction of Medications last revised 11/2/2015 included, "Staff shall follow standard infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, keeping equipment clean and so on) as these apply to preparation and administration of medications. Medication will be in their original, labeled containers in a locked storage area at room temperature unless otherwise indicated by the pharmacy", and "Resident who wish to keep their medications in their room must have a locked container that both they and the nurse can access. Any medication that could cause significant harm to another person if accidentally ingested must be kept in this locked box", and "Medication are to be prepared immediately prior to the time of administration."	F 441		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings.	F 505		4/27/16

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F 505	Continued From page 93 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician or respond to a decreased serum ionized calcium level for 1 of 6 residents (R42) reviewed for unnecessary medications. Findings include: R42 was admitted to the facility on 8/5/15, with diagnoses that included, osteoarthritis, osteoporosis, and heart failure according to the facility Face Sheet. R42's care plan dated 10/14/15, included diagnosis of osteoporosis and instructed staff to obtain scheduled labs per provider's orders. R42 was admitted to the hospital from 12/30/15 through 1/8/16, and the hospital lab reports indicated on 12/31/15, the serum calcium levels were at the low end of normal range of 8.5 milligrams/deciliter (mg/dl-range is 8.5 to 10.4 mg/dl) and on 1/4/16, the labs also indicated the ionized calcium levels were low at 1.05 millimoles per Liter (mmol/L - range is 1.12-1.32 mmol/L). R42's Physician Orders did not reflect the addition of a calcium supplement between October 2015 and March 2016, however the orders did reflect the discontinuation of the Fosamax on 2/1/15. R42's Nursing Progress Notes reviewed between 12/1/16 through 3/18/16, did not reflect the Physician Order to discontinue Fosamax or address the calcium lab monitoring.	F 505	The hospital discharge summary/H&P for resident 42 was provided to the medical providers of her care. Recommendations from the consultant pharmacist were provided to the medical provider each month. During the survey process the physician assistant was contacted regarding the lack of response. She stated that she was aware of the lab findings and although they were abnormal, they were expected findings given R42's condition. She had chosen to take no action on these labs but had not documented her rationale. A request was made of her to please document this or take action and she agreed to document. The facility recognizes that we do not have the authority over provider choice to act or refrain from action related to any persons lab results. HOW WILL FACILITY ENSURE LAB RESULTS ARE PROMPTLY REPORTED: As a systematic change, the facility will ask the consulting pharmacist to develop a form that can be sent to the medical provider when a response has not been received from them in relation to a requested action SUCH AS LAB REPORTS. This notification will be provided by April 27, 2016 and will be further discussed if needed at our monthly meeting May 4, 2016. FURTHERMORE: Nurse Managers will make note of new lab orders and review	

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F 505	Continued From page 94 R42's Physician Visit Note dated 2/1/16, indicated the physician discontinued the Fosamax (used to treat osteoporosis) possibly related to problems with a sore throat and R42 had been on it for three years. There was no mention of calcium supplementation. The Physician Progress Notes did not reflect and lacked consideration or evaluation of calcium supplementation after the abnormal low level of ionized calcium found on 1/4/16. During an interview on 3/17/16, at 3:55 p.m. RN-B was able to obtain the lab values when R42 was hospitalized. RN-B stated hospital calcium levels obtained on 1/4/16, were low at 1.05. RN-B stated a physician had not followed up with the abnormal lab values. During an interview on 3/18/16, at 10:29 a.m. the director of nursing (DON) explained nurse managers prompt the physician during rounds so they are getting the information twice. The DON stated the staff are knowledgeable on how to check lab results. The DON indicated that it was the nurse's responsibility to follow up with all lab draws ordered, but providers also have the responsibility to respond to abnormal lab orders. The DON indicated on 3/18/16, the physician assistant reviewed the labs from when R42 was in the hospital. Facility policy for abnormal lab findings was requested and not received.	F 505	the results when they are available. The provider receives these same results and is notified by the clinic system; HOWEVER, if the provider fails to respond to an abnormal lab result, the facility Nurse Manager will contact the provider to request a response. This practice will start immediately. A verbal request will be utilized until the afore mentioned form is developed.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514		4/27/16

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F 514	Continued From page 95 resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident medical records were complete which included physician visit progress notes for 7 of 31 residents (R39, R29, R18, R28, R34, R51, R16) medical records reviewed during the survey process. Findings Include: R39's face sheet revealed R39 was admitted in 2015, and was diagnosed with dementia with behavioral disturbance and depressive disorder. R39's medical record revealed no evidence of physician visit progress notes from 5/20/15-3/15/16. However, R39's physician visit progress noted dated 7/17/15, 10/5/15, 10/21/15, 12/16/15, and 2/10/16, were located at the clinic and not in R39's medical record, as required. R29's face sheet revealed R29 was admitted in 2012, with diagnoses of heart failure and chronic kidney disease. R29's medical record revealed no	F 514	All documents requested for the residents listed 39, 29, 18, 28, 34, 51, 16 have been received. There are no other known missing records at this time. Nurse Managers and Director of Nursing are available 24 hours a day to retrieve documents from the Gundersen System if a document is found missing and is needed in an emergency situation. PLAN TO PREVENT FUTURE OCCURANCES: The provider has already developed a template that will create a pathway for the digital transfer of records from one online medical record to the other. HOW WILL FACILITY MONITOR TO ENSURE COMPLIANCE: A preliminary audit was done to check on the transfer of records after that template was put in place and all visit progress notes did transfer successfully. After one	

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F 514	Continued From page 96 evidence of physician visit progress notes from 5/20/15-3/15/16. However, R29's physician visit progress notes dated 7/17/15, 10/7/15, 10/21/15, and 1/27/16, were located at the clinic and not in R29's medical record, as required. R18's face sheet revealed R18 was admitted in 2015, with diagnoses of history of falling, heart failure, anxiety and depressive disorders. R18's medical record lacked evidence of physician visit progress notes. However, R18's physician visit progress notes dated 9/9/15, and 11/9/15, were located at the clinic and not in R18's medical record, as required. R28's face sheet revealed R28 was admitted in 2015, with diagnoses of persistent atrial fibrillation and dementia without behavioral disturbance. R28's medical record lacked evidence of physician visit progress notes since the time of admission. However, R28's physician visit progress notes dated 5/20/15, 8/12/15, and 12/16/15, were located at the clinic and not in the R28's medical record, as required. R34's face sheet revealed R34 was admitted to the facility in 2013, with diagnoses of muscle weakness according to facility medical record face sheet. R34's medical record lacked evidence of physician visit progress notes from 5/2015-3/15/16. However, R34's physician visit progress notes dated 7/15/15, 9/4/15, and 11/4/15, were found at the clinic and not in R34's medical record, as required. R51's face sheet indicated R51 was admitted in 2015, with diagnoses of compression fracture and dementia. R51's medical record lacked evidence of physician visit progress notes from 11/19/15-3/15/16. However, R51's physician visit progress notes dated 12/17/15, and 2/24/16,	F 514	month another audit will be done to determine if the template continues to be effective in the transfer of records. IF IT IS NOT EFFECTIVE, THE FACILITY WILL IMMEDIATELY CONTACT THE PROVIDER AND I.T.DEPARTMENT TO FIX ANY TECHNICAL PROBLEMS.	

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were located at the clinic and not in R51's medical record, as required.

R16's face sheet indicated R16 was admitted in 2015, with diagnoses of psychosis and chronic kidney disease. R16's medical record lacked evidence of physician visit progress notes from 5/2015-3/15/16. However, R16's physician visit progress notes dated 6/17/15, 10/22/15, 12/21/15, and 2/24/16, were located at the clinic and not in R16's medical record, as required.

During an interview on 3/17/16, at 3:30 p.m. director of nursing (DON) verified the facility had not received physician visit progress notes back from the physician in a timely manner. The DON stated the facility had discussed the concern with the physician with no improvement, therefore they would have to find another approach at obtaining the notes in a more timely manner.

The Electronic Clinical Record policy did not reflect what was required in the resident's medical record, however did indicated: "all resident care documentation is to be completed within the Matrixcare system unless the system lack capability to meet the documentation needs of the facility.", and "b. in the event that documentation cannot be completed within the Matrix system for any reason, that documentation may be completed on paper in facility approved format to be scanned into digital form at a later date."

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated March 17, 2016, GUNDERSEN HARMONY CARE CENTER was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2016

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 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The GUNDERSEN HARMONY CARE CENTER is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1964, addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 35 beds at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 During the facility tour between the hours of 09:30 AM and 12:30 PM on 03/17/2016, observation revealed penetrarations in the ceiling around ductwork in the A/C- storage room of the memory Lane Wing. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 029	Will purchase fire caulk to apply to noted areas and will replace the portion of sheetrock to maintain a fire block in the A/C room in the Memory Lane wing. This will be completed by the Maintenance Director by April 27, 2016	4/27/16

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**03/17/2016**

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GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 discovery.	K 029		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:30 AM and 12:30 PM on 03/17/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	A policy will be written for when the automatic sprinkler system is out of service for more than four hours in a 24-hour period. This policy will include information about which people should be notified, whether the building is to be evacuated or if an approved fire watch will be provided until the sprinkler system has been returned to service. The Maintenance Director will be responsible for this and will create the policy by April 27, 2016	4/27/16
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period,	K 155		4/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**03/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 4 the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:30 AM and 12:30 PM on 03/17/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 155	A policy will be written for when the fire alarm system is out of service for more than four hours in a 24-hour period. This policy will include information about which people should be notified, whether the building is to be evacuated or if an approved fire watch will be provided until the alarm system has been returned to service. The Maintenance Director will be responsible for this and will create the policy by April 27, 2016	