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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3VTT
Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245270**

2. STATE VENDOR OR MEDICAID NO.
(L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **WHITEWATER HEALTH SERVICES**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **09/24/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **55** (L18)

13. Total Certified Beds **55** (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
	55			
(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 :
Gary Nederhoff, Unit Supervisor 10/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/11/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Electronically delivered

CMS Certification Number (CCN): 245270

October 11, 2018

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

Dear Administrator:

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

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

Effective September 18, 2018 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2018

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: Project Number S5270027

Dear Administrator:

On August 27, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 9, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 24, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 18, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 9, 2018, effective September 18, 2018 and therefore remedies outlined in our letter to you dated August 27, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3VTT
Facility ID: 00942

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2. STATE VENDOR OR MEDICAID NO. (L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **WHITEWATER HEALTH SERVICES**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2017**

6. DATE OF SURVEY **08/09/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12. Total Facility Beds **55** (L18)

13. Total Certified Beds **55** (L17)

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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
	55			
(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 :
Stephanie Powers, HFE NE II 09/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/14/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

Electronically delivered
August 27, 2018

Whitewater Health Services
Attn: Administrator
525 Bluff Avenue
St. Charles, MN 55972

RE: Project Number S5270027

Dear Administrator:

On August 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<u>Informal Dispute Resolution</u> - **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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (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 September 18, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 18, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 9, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 9, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING ______ B. WING ______	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on August 6, 7, 8 & 9, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On August 6, 7, 8 & 9, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		9/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/05/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING ______ B. WING ______	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to promote personal choices regarding cares/services for 1 of 2 residents (R27) who was interviewed for bathing choices. Findings include: R27's Admission Record dated 8/9/18, identified an admit date of 6/13/18, with diagnoses of quadriplegia, abnormalities of gait and mobility, congestive heart failure (CHF), type 1 diabetes mellitus, and muscle weakness. R27's significant change, Minimum Data Set (MDS) and assessment dated 7/12/18, identified R27 to have intact cognition and is totally	F 561	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING ______ B. WING ______	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 561	Continued From page 2 dependent on staff for bathing. R27's baseline care plan, dated 7/3/18, indicated bathing needs 2 assist and bath days are on Fridays. Care plan lacked preference of bath, shower or bed bath was left blank. Also the care plan had not identified how often resident would like a bath. R27's current Care Plan, dated 6/13/18, identified a focus of ADL self-care deficit related to physical limitations, weakness, instability, and quadriplegia. Goal identified R5 will be clean, dressed, and well-groomed daily to promote dignity and psychosocial well-being, with an intervention to assist with bath/shower as needed. During observation and interview on 8/6/18, at 2:03 p.m. R27 was seated in his wheelchair located in his room watching television. R27 stated, I only get a bath on Fridays, It would at least be nice to have one in the middle of the week. I would like one every day if I could, but they have a lot of people here and I suppose they only have so much help. On asking if the staff had asked how many baths/showers he preferred, he said, "They never asked me how many showers I would like to have." During interview on 8/8/18, at 9:11 a.m. nursing assistant (NA)-A stated, I think the DON asks how often a resident would want a bath when they first get here. If someone asks for an extra bath and I have time I would give them one. During interview on 8/9/18, at 9:15 a.m. director of clinical services (DOCS) stated that all residents are asked upon admission on the baseline care plan in regards to their bathing	F 561	submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F561 R27 unavailable for re-interview. Deceased 8/21/2018. Residents at facility re-interviewed regarding bathing preferences. Care Plans updated to reflect changes. Facility Guidelines for meeting Self-Determination through resident choice reviewed. Nursing staff to receive re-education on Person-Centered Care Planning at 9/5 & 9/6 (NA) and 9/11 & 9/12 (Nurse) monthly meetings. DON to complete weekly audit x2 months, then bi-weekly audit x2 months and then monthly audit x2 months to ensure compliance with resident bathing preferences is met. Audit results and data will be presented and reviewed at monthly QAPI meeting. QAPI Committee will make any recommendations/ changes at that time as necessary.	

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F 561	Continued From page 3 frequency. During interview on 8/9/18, at 9:17 a.m. DOCS verified R27's showers are scheduled for Fridays, when his preference is daily or at the very least, one extra shower in the middle of the week. My expectation would be to ask a resident their bathing preference, between a shower or a bath, and how often, upon admission. Facility documentation of bathing, identified R27 received bathing assistance on 7/13/18, 7/20/18, 7/27/18, and 8/3/18. Policy for bathing preferences was requested and not provided.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		9/18/18

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in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow up on resident council and grievance concerns regarding incorrect diet slips, and late meal service, were resolved in a timely manner for 7 of 7 residents (R1, R2, R3, R4, R14, R19, and R23) who voiced complaints, reviewed for resident council.

Findings include:

RESIDENT COUNCIL MINUTES COMPLAINTS:

During record review of the resident council meeting minutes for May, June, and July of 2018, the following complaints were made:

5/16/18-meals continue to be late, diet slips are incorrect, and complaints of cold food. On the attached, Resident Council Response Form, these complaints were not addressed, and not resolved.

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Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within

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6/8/18-meals continue to be late (mostly supper). Attached Resident Council Response Form is blank, and not resolved.

7/13/18-Currently looking for a new dietary manager, not as many food complaints, not getting weekly menus. On the attached, Resident Council Response Form, these complaints were not addressed, and not resolved.

During record review of Grievance Reports for May, June, and July of 2018, the following grievances were made:

GRIEVANCES:

5/27/18, an individual initiating complaint is the West Wing Residents. The concern is, "Residents complain that food is taking too long be served, want to know what time meals are going to be served, sitting at the table too long. One unidentified independent resident received breakfast at 8:30 a.m. Documentation of facility follow-up: I will be more vigilant after talking with staff that filed the complaint. Plan of correction dated, 5/29/18-start plating by 7:40 - 7:45 a.m., so the big cart is ready to go at 8:00 a.m. Call down to nurses station if behind, so messages can be relayed to residents that are waiting to be aware of the time and if special requests come back during plating; to acknowledge the request and wait till the end of service to make it. Requests should be made no later than 1.5 hours before service to give the cook enough time to prepare if needed.

6/21/18, an individual complaint from R11, meals are brought late and we have to sit too long and wait for supper. Documentation of facility

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ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

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Residents R1, R2, R3, R14, R19, and R23 have been interviewed to review their concerns regarding meal times, incorrect diet slips, food temperatures, and weekly menu delivery.

Dietary staff to be re-educated on meal serving times, food temperatures, menu delivery to rooms, making and communicating changes to the menu, and alternate food choice being available and served timely.

Resident diet slips to be reviewed and corrected by 09/18/18.

All residents have the potential to be impacted by this practice.

Facility Grievance Policy and Procedure to be reviewed and revised if needed.

Staff to be re-educated on Grievance Policy and Procedure on 09/12/18.

Resident Council concern registration process to be reviewed and revised as needed.

Management staff to be re-educated on Resident Council concerns and the process for responding to resident

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follow-up: Talked with dietary manager about supper being late consistently. Resolution of Grievance/Complaint: Talked with [R11] and told her dietary staff is working on getting dinner out by 5 p.m.

7/23/18, an individual complaint from R23, meals are running up to 2 hours late, sometimes I'm afraid we're not going to get food at all. Documentation of facility follow-up: we are short staffed, we are awaiting fingerprint and background on a couple of employees, and then we should be set for proper meal service. Resolution of Grievance/Complaint: grievance was not resolved, there has been no new employees hired, signed 7/30/18.

7/23/18, an individual complaint from R3, We used to get weekly menus in our room, what happened? Documentation of facility follow-up: Short a manager and staff to print out and deliver. Looking to hire new manager. Still interviewing. Resolution of Grievance/Complaint: not resolved, a manager has not been hired, dated 7/30/18.

RESIDENT COUNCIL MEETING:

A resident council meeting was scheduled on 8/7/18, at 9:59 a.m. and 7 residents R1, R2, R3, R4, R14, R19, and R23, participated with one (Minnesota department of health (MDH) surveyor present.

During the interview on 8/7/18, at 10:16 a.m. R23 was assessed 6/20/18 as having an intact cognition stated, I think they have good intentions but then it just never happens, in response to addressing our concerns with the food being served late and diet slips not matching.

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concerns.

Meal service times, accuracy of diet slips, and food temperatures audits will be completed 2 times a week for 1 month, weekly for 2 months and then monthly for 2 months.

Dietary Manager will be responsible to monitoring.

Audit results and data will be presented and reviewed at monthly QAPI meeting. QAPI Committee will make any recommendations/ changes at that time as necessary.

Corrective action will be completed by 9/18/2018.

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During the interview on 8/7/18, at 10:19 a.m. R1 was assessed 4/29/18, as having an intact cognition, and R3 was assessed 4/30/18, as having an intact cognition, both have complaints about vegetables that are not cooked all the way, and lots of times the diet slips are incorrect, meaning what it says on our diet slips does not come on our plate.

During the interview on 8/7/18, at 10:23 a.m. R23 stated, for supper sometimes you can be a few minutes early and sometimes it is 45 minutes late. It hasn't really gotten any better, from response of resident council minutes from June of this year with the food being served late. At 10:25 a.m. R23 further stated, they do not always have the second choice, what is says on the monthly calendar is not necessarily what you get on your plate, this has been a problem for a while now and still has not been resolved when it comes to having the incorrect information on your diet slips.

During interview on 8/7/18, at 10:26 am. R19 was assessed 7/6/18, as having an intact cognition and stated, if you get second choice, it will not come hot, and the kitchen wants to know 2 hours ahead of time if you want what the second choice is, and when the menu isn't right and you decide you want second choice, they don't always give it to you, or if they do it tastes like they heated up in the microwave.

During observation and interview on 8/7/18, at 12:15 p.m. on asking R15 how the lemon cake was, R15 said they did not make lemon cake, it is vanilla cake.

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During interview on 8/7/18, at 12:20 p.m. R3 stated everything was good, but the cake is not lemon like it says on the diet slip, it tastes plain.

During interview on 8/7/18, at 12:20 p.m. This surveyor requested a piece of cake from the kitchen and it was confirmed through taste there was no lemon taste. Observed to be a yellow cake with cream colored frosting.

During interview on 8/7/18, at 12:21 p.m. Cook (C)-A verified the cake served today was supposed to be lemon cake and verified it was a yellow cake. C-A stated, the cake is just regular yellow cake, the truck never brought me my lemons, and "I couldn't make the lemon cake."

During interview on 8/7/18, at 12:33 p.m. registered nurse (RN)-B stated in the west dining room they do complain a lot if the food on the plate does not match the menu. This has been happening a lot ever since they don't have a dietary manager anymore.

During interview on 8/7/18, at 12:34 p.m. licensed practical nurse (LPN)-B stated they haven't had a dietary manager for a month or two, they just interviewed and hired one today, so things aren't always ordered right. So the kitchen has to make what they have on hand. "Sometimes the menu does not match what is being served." The residents have an alternate choice they are allowed to order right away. The kitchen requests that they give a 2 hour notice but they don't have to.

During interview on 8/7/18, at 12:38 p.m. C-A stated, we have not had as dietary manager for 2-3 months, our regional manager has been

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doing the ordering and he comes once a week to do the ordering, so I don't always have what I need to make what is on the menu. "I do my best."

During interview on 8/7/18, at 12:38 p.m. Dietary aide (DA)-A stated, we have had to change the menus at least twice a week since we have had no dietary manager, and yes the residents do complain. At 12:43 p.m. DA-A verified that the big menu hanging on the wall in front of the dining room is incorrect, with the assorted ice cream for dessert. We did have one resident ask for ice cream it was R1 and we gave it to him. The actual resident menu indicated it was supposed to be lemon cake, but it was neither of them, it ended up being yellow cake.

During interview on 8/07/18, at 12:45 p.m. interim dietary manager (IDM)-A verified there has not been a dietary manger here for 2-3 months. Further verified there have been times that the menu items posted are not always being served. IDM-A stated, "Yes the items on the menu have not been correct sometimes." IDM-A verified that lemon cake was not served like it stated on the menu today and that the menus did not match for today. One menu said assorted ice cream and one menu said lemon cake, neither were served it was plain yellow cake. IDM-A stated, "We are going to fix that, I am personally going to go through all of the menus and make sure they are accurate. I would expect the residents to get what the menu says."

During interview on 8/09/18, at 9:42 a.m. director of clinical services (DOCS), stated, "My expectations are that grievances should be responded to timely, a solution is reached and

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follow up is completed to be sure it continues to be resolved.

Facility policy, Menus, dated May, 2014, indicated 6. Menus are served as written, unless changed in response to preference, unavailability of an item, or a special meal. 8. Menus are posted in nutrition services department, dining rooms and resident/patient care areas.

Facility policy, Grievances, dated 1/9/17, indicated the facility will seek to resolve concerns, complaints or grievances, and provide residents, responsible parties, staff and others feedback and resolution in a timely manner.

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F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		9/18/18

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services

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F 582	Continued From page 11 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for 2 of 2 residents (R6, R20) reviewed for Medicare A coverage. Findings include:	F 582	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other	

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R6 was admitted to facility 4/24/18, as identified on the form CMS-20052 (a SNF [skilled nursing facility] Beneficiary Protection Notification Review) and had received services covered by Medicare A. The form identified R6's last covered day under Medicare A as 5/22/18, and the resident continued to reside in the facility. A "Notice of Medicare Non-coverage-Form CMS 10123 (NOMNC) generic form (an advanced notice providing information about termination of services) was provided; however, there was no evidence a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (a liability notice that services will no longer be covered by Medicare A) was provided as required since 5/7/18. R6's medical record also lacked evidence that the SNFABN form was provided even though the resident remained in the facility.

R20 was admitted to facility 5/31/18, as identified on the form CMS-20052 and had received services covered by Medicare A. The form identified R20's last covered day under Medicare A as 7/2/18, and the resident continued to reside in the facility. A NOMNC generic form was provided; however, there is no evidence that a SNFABN was provided as required since 5/7/18. R20's medical record also lacked evidence that the SNFABN form was provided even though the resident remained in the facility.

During an interview on 8/9/18, at 8:49 a.m. licensed practical nurse (LPN)-B was asked for a SNFABN or explanation for the absence of the form for both R6 and R20. LPN-B replied, "We don't have that [regarding a SNFABN], are you saying we should?" LPN-B and administrator

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individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F582:

Specific residents affected by alleged deficient practice: R6 provided the corrected SNFABN form. Resident stated he had no questions and understood all aspects of coverage. R20 discharged from facility 8/20/2018.

Residents whose Medicare part A ends and they remain in the facility are issued a SNFABN along with Medicare denials according to CMS guidelines. MDS Coordinator will review requirements of SNFABN by 9/18/2018. MDS Coordinator will audit residents whose Medicare A coverage ends and they remain in facility. Results will be reviewed daily at morning

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F 582	Continued From page 13 were asked to confirm that the SNFABN had not been provided for either R6 or R20 and both indicated that the form had not been completed for either resident. A policy on beneficiary liability notices was requested, however, facility failed to provide this policy.	F 582	IDT Meeting.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) an assessment related to bed mobility for 2 of 2 residents (R24, R8) and transfers and toileting for 1 of 2 resident (R24) reviewed for activities of daily living (ADLs). Findings include: According to the Long Term Care Facility Resident Assessment Instrument User's Manual version, 3.0, read: code total dependence "if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unable or unwilling to perform any part of the activity over the entire 7-day look-back period." R24's quarterly MDS dated 6/20/18, was coded demonstrating R24 as being "totally dependent" in the area of bed mobility, transfers and toileting.	F 641	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within	9/18/18

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	245270	A. BUILDING ______ B. WING ______	08/09/2018

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F 641

Continued From page 14

Nursing assistant documentation of resident R24's activities of daily living (ADL) self performance between 6/14/18, and 6/20/18 shows the following:

-bed mobility was coded 45 times; 10 occurrences were coded as "total dependence" and the remaining 35 occurrences show resident R24's did participate during ADL-bed mobility.

-transfers was coded 30 times; 14 occurrences were coded as "total dependence" and the remaining 16 occurrences show resident R24's did participate during ADL-transfers.

-toileting was coded 36 times; 17 occurrences were coded as "total dependence" and the remaining 19 occurrences show resident R24's did participate during ADL-toileting.

On 8/7/18, at 1:44 p.m. licensed practical nurse (LPN)-B was interviewed and stated she was the nurse responsible to complete coding on the MDS. LPN-B explained she followed CMS' "rule of three" when coding self performance ability on the MDS adding, "When an activity occurs at a level three or more times, we code that level of care." LPN-B expressed the charting in R24's medical record showed "more often than not R24 was total [assist]" in the listed care areas.

At this time, the director of clinical services (DOCS) showed a decision making tool available in the facility electronic medical record which provided direction to code total dependence only if all documentation shows "total dependence" during the 7 day look-back period. LPN-B acknowledged that charting showed R24 did, at times, participate in bed mobility, transfers and

F 641

ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F641
R24□s 6/20/2018 Quarterly MDS & R8□s 2/14/2018Annual MDS corrected to accurately reflect residents□ status.

Residents who have MDS assessments completed have the potential to be impacted by this practice. An audit of residents who have been identified as needing total assist with ADL tasks in the MDS will be reviewed to ensure that coding is accurate.
Modifications/correction requests will be submitted when indicated.

Education was provided to the MDS coordinator by the DON or designee regarding the need for accuracy with MDS coding and the definition of total assistance as outlined in the RAI manual on 9/5/2018.

MDS Coordinator will monitor Care Plans and ensure accuracy of MDS assessments on admission, quarterly, annually and with any significant change. DON or designee will audit MDS entries on three residents weekly for four weeks, two residents weekly for four weeks, one resident weekly for four weeks then one resident monthly for three months.

Results of monitoring will be reported to

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F 641	Continued From page 15	F 641		

toileting during the look-back period of 6/14/18 to 6/20/18. LPN-B stated R24's quarterly MDS dated 6/20/18, had been coded incorrectly and required correction. Further, DOCS stated they would complete and submit a correction MDS to CMS.
R8's face sheet indicated R8 was admitted to the facility on 12/11/15, with Diagnoses include: Dementia with behavioral disturbance, Diabetes, major depressive disorder, osteoarthritis.

R8's care plan dated initiated 4/3/17, indicated R8 has impaired mobility and requires assist of two to turn, reposition and boost up in bed.

R8's Annual MDS dated 2/14/18, was coded demonstrating R8 as bed mobility occurred once or twice through out a 7-day look back period for a resident that is totally dependent in the area of bed mobility, transfers and toileting.

On 8/8/18, at 12:40 p.m. interview with nursing assistant (NA)-A stated, R8 used to talk, now she doesn't talk anymore, she requires total assistance for everything, totaling dependent on staff.

On 8/8/18 at 12:44 p.m. LPN-A stated, R8 had a slow decline over the past few month and would help with turning, however she no longer helps with turning, she is completely dependent on staff to do the tasks.

During an interview on 8/9/18, at 3:02 p.m. the director of clinical services (DOCS) was asked about R8's total dependence on staff for meeting captivities of daily living. DOCS had reviewed R7's MDS and said that she would have interviewed staff to make sure the decline in mobility was accurate during the seven day look

Provider's Plan of Correction (F 641):

QAPI Committee monthly and any recommended changes implemented at that time.

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F 641	Continued From page 16 back days. DOCS said they knew that bed mobility for R8 had occurred more that once or twice in a seven day look back period. DOCS then said the MDS would be inaccurately coded for mobility. A policy was requested but none provided.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		9/18/18

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F 657

Continued From page 17

by:
Based on observation, interview, and record review, the facility failed to revise resident care plan with updated interventions, for 1 of 3 residents (R13) reviewed for use of splints, for 1 of 7 residents (R22) reviewed for activities of daily living (ADLs), and for 1 of 5 residents (R27) reviewed for advanced directives.

Findings include:

R13's face sheet indicated R13 was admitted readmission to the facility on 5/9/18. Diagnosis included contractures.

R13's care plan printed on 8/9/18, indicated diagnoses of spastic quadriplegic cerebral palsy, impaired mobility, contractures, with intervention of : R8 is to be positioned in supine position (lying flat) 2-3 x/day to encourage full body extension with blue braces on LE's (lower extremities) - blue bilateral knee extensions braces wear 3 x/day for 1-2 hours each on in bed only. Monitor skin for redness & breakdown.

On 8/7/18, at 10:14 a.m. R13 had been observed up in wheelchair in lobby watching TV. No blue braces on lower extremities.

Therapy communication note 2/13/17- 6/12/17, initial by certified occupational therapy aide (COTA)-A on 6/12/17, when braces where discontinued by occupational therapy.

On 8/9/18, at 10:48 a.m., nursing assistant (NA)-A stated, "I have not seen them [knee braces] in a while, they are not in her room and possibly have been discontinued."

F 657

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Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F657
Specific residents: R13 interventions (splints), R22 (ADL□s) and R27 (advance directive) were updated immediately upon notification.

Residents who experience changes in condition, require use of splints or devices, assistance with ADL tasks, and who require code status updates have the

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F 657	Continued From page 18	F 657		

On 8/9/18, at 2:34 p.m., licensed practical nurse (LPN)-A, said, "I think they have been discontinued." Further stated, "The braces were never removed from the care plan."

On 8/9/18, at 4:48 p.m. interview with director of clinical services (DOCS), stated her expectation would be that care plan would have been updated to reflect current interventions.
R22's Admission Record dated 8/9/18, indicated diagnoses of dementia with behavioral disturbances, infarct (stroke), major depressive disorder, and obsessive compulsive disorder.

R22's Care Plan dated 4/13/18, indicated R22 needed assist with ADLs related to dementia and other diagnoses. With a goal to be clean, dressed, and well-groomed daily to promote dignity and psychosocial well-being. Intervention is needed assist of staff for personal hygiene. Requires staff to brush his teeth twice a day and as needed.

R22's Order Summary Report, signed and dated by a medical provider on 8/7/18, indicated R22 to receive honey thickened liquids.

Untitled and undated facility document, AM Care, indicated each resident will receive a.m. care. The resident will receive person centered care based on the resident's needs, schedule, abilities and desires. Dental care, hair care and clothing dressing is included at the extent of assistance required and desired by the resident.

During observation on 8/8/18, at 8:47 a.m. R22 was sitting in his Broda chair in his room, appeared well groomed. When R22 was asked if his teeth were brushed this morning, he stated he

Provider's Plan of Correction (F 657):

potential to be impacted by these practices.

The DON or designee will provide education to the MDS Coordinator on 9/5/2018 regarding Care Planning and CMS Guidelines.

Audits to ensure accuracy of Care Plans, Care Guides and assigned Tasks will be performed on 10% of the facility population weekly x8 weeks then bi-weekly x2 months and then monthly x2 months. Results of audit will be reported to QAPI Committee monthly and any recommended changes implemented at that time.

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did not get his teeth brushed this morning, but stated he could probably use it.

During interview on 8/8/18, at 8:51 a.m. nursing assistant (NA)-A stated she would have guessed his teeth got done this morning when the night aides got him up. NA-A further stated, "His top ones look ok, but yeah, his bottom ones look bad, the gums are red." I guess I wouldn't feel comfortable using a toothbrush, he is on thickened liquids, I would use the mouth swabs. People who are on thickened liquids are an aspiration risk, we don't use a toothbrush we use the mouth swabs. NA-A pulls a bag of mouth swabs out of R22's drawer and stated, "See this is what they use (bag of toothettes), he doesn't even have a toothbrush." NA-A then swabs R22's mouth and R22 is compliant.

During interview on 8/9/18, at 9:25 a.m. Director of Clinical Services (DOCS) stated it is a standard of practice in the facility if a resident is an aspiration risk, that they use the swabs verses a toothbrush. DOCS verified that the R22's care plan does say to use a toothbrush and should be person centered and revised as needed.

R27's Admission Record dated 8/9/18, identified an admit date of 6/13/18, with diagnoses of quadriplegia, abnormalities of gait and mobility, congestive heart failure (CHF), type 1 diabetes mellitus, and muscle weakness.

R27's significant change, Minimum Data Set (MDS) an assessment, dated 7/12/18, identified R22 to have intact cognition and is dependent on staff for most activities of daily living (ADLs).

R27's baseline care plan, dated 7/3/18, indicated

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F 657	Continued From page 20 R27 to be a full code status. R27's current Care Plan, dated 6/13/18, identified a focus of resident's advanced directive is: DNR/DNI (do not resuscitate/do not intubate). Goal identified residents wishes will be honored, with an intervention of full code, and cardiopulmonary resuscitation (CPR) will be performed as ordered. R27's provider of life sustaining treatment (POLST) signed by a physician 7/10/18, identified do not resuscitate, do not intubate (DNR/DNI). R27's Order Summary Report, signed by a medical provider on 7/10/18, no code status was indicated. During interview on 8/8/18, at 9:20 a.m. director of nursing (DON) verified R27's POLST order indicated to DNR/DNI. Further verified R22's care plan intervention is R22 is a full code and to perform CPR as needed. DON stated, it looks like licensed practical nurse (LPN)-B never updated the intervention in the care plan. It should be DNR/DNI. During interview on 8/8/18, at 9:35 a.m. LPN-B stated I typically put in the code status orders for the residents. LPN-B verified the code status on the POLST does not match the care plan intervention. LPN-B stated, we are in the phase of trying to figure out who will be responsible to update the care plan. Requested a policy for Care Plan revision and was not received.	F 657		
F 658	Services Provided Meet Professional Standards	F 658		9/18/18

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F 658 SS=D	Continued From page 21 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to document medications given for 1 of 1 resident (R34) reviewed for a closed record. This had the potential to affect all new admissions into the facility. Finding included: R34 admitted on 5/24/18, with diagnosis of congestive heart failure, diabetes, atrial fibrillation. R34 hospice admission contract indicated, hospice services started on 5/24/18, at 3:30 p.m. Review of R34's progress notes, on 5/24/18, at 9:21 p.m. read, "Resident did receive "cocktail" of anxiety medications at 2000 [8:00 p.m.] even though medication administration chart does not show it." During an interview with the director of clinical services (DOCS) on 8/9/18 at 1:57 p.m., the DOCS revealed it is a professional standard of practice to identify what medications were given and her expectation would be to have completed a paper medication administration record (MAR) if the computer was not available. During an interview with registered nurse (RN)-A	F 658	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F658 Facility allegedly failed to document	

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F 658	Continued From page 22 on 8/9/18 at 2:37 p.m., revealed she was the nurse who administered the "cocktail" of medications R34 received on 5/24/18. RN-A also indicated she could have used a paper MAR to document the medications (that were part of the cocktail) but did not want to take the time to complete it. Policy titled Administration Procedures for All Medications dated August 2014 reads; -check MAR for order -check label against the order on the MAR -after administration, document in the MAR	F 658	medication given to R34. R34 deceased 5/20/2018. Residents who require staff administration of medications have the potential to be impacted by this practice. Staff re-education will be provided by the DON or designee on September 11 and 12. Education will include review of Medication Administration Procedures for Medications including the use of paper MAR if computer is unavailable. Administration Procedure for Medications policy and procedure has been placed in Nursing Resource Binders located at each Nurse s Station. Audits by direct observation of medication administration to individual residents will be completed by DON or designee three times weekly for four weeks, twice weekly for four weeks, weekly for four weeks then monthly for three months.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		9/18/18

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F 661	Continued From page 23 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive discharge summary had been completed and provided to the resident and/or their representative, and the physician for 1 of 1 resident (R32) who was discharged to home. Findings include: R32's Minneapolis VA HCS note received 6/12/18, identified R32's admission orders to the nursing home which dictated he had good rehabilitation potential, and a good prognosis. R32 had several medical diagnoses including diabetes (disease causing high blood sugars), chronic kidney disease, sleep apnea and ulcerative colitis (a chronic inflammatory bowel disease). R32 was identified as needing supervision assistance with grooming and toileting, however, required total assistance with	F 661	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements	

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F 661	Continued From page 24 baths and showers. The listed physician orders also included orders for R32 to be evaluated for physical and occupational therapy (PT and OT). Further, R32 had bladder incontinence and displayed wandering behaviors. R32's Nursing Admission/Readmission Evaluation dated 6/13/18, indicated R32 admitted to the facility on 6/13/18, under the care of local physician for respite care. R32 was identified as independent with bed mobility, transfers, ambulation with a 4 wheeled walker and independent with toileting; however, required limited assistance with personal hygiene and supervision for eating. It also indicated he needed physical help with bathing. The assessment noted a "surgical incision" located on the "abdomen" and the presence of an ileostomy (Ileostomy is a stoma constructed by bringing the end or loop of small intestine out onto the surface of the skin, or the surgical procedure which creates this opening. Intestinal waste passes out of the ileostomy and is collected in an artificial external pouching system which is adhered to the skin) in the right lower quadrant of the abdomen. Furthermore, the assessment indicated R32 was alert and orientated with urinary incontinence of small amounts 3 to 4 times daily, and was planning to return home but did not require community resources. R32's physical therapy (PT) progress and discharge note dated 6/18/18, indicated that care was initiated on 6/14/18, and was discontinued on 6/18/18. Also, the note stated he had not met the long term goal to "improve Tinetti Balance Score to 19/18 to be able to ambulate 500 feet with 4WW [4 wheeled walker] on even surfaces with MOD (1) [moderate assistance of 1 person] in	F 661	under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F661 Specific Residents: Completed and mailed R32 a copy of his discharge summary. Residents who are discharged from the facility have the potential to be impacted by this practice. The DON or designee will provide education to the interdisciplinary team and licensed nursing staff regarding the discharge process for residents who are discharged from the facility at 9/11 & 9/12 nurse□s meeting. Audits to ensure completion of Discharge Summaries will be completed by DON monthly. Results of these audits will be reviewed at monthly QAPI meeting and recommendations/changes implemented as necessary at that time.	

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F 661	Continued From page 25	F 661		

order to be discharged to home with 4 stairs and return to PLOF [previous level of function]." The discharge plan stated R32 was going to discharge home with "possible home health."

R32's occupational therapy (OT) progress and discharge note dated 6/18/18, indicated that care was initiated on 6/14/018, and discontinued on 6/18/18; furthermore, he had not met the stated long term goal to "perform UE HEP [upper extremity home exercise program] with independence in order to maintain current level of function upon d/c [discharge]." The discharge plan stated: "Patient here for short term VA [Veterans' Administration] stay, d/c'd home."

R32's progress note dated 6/16/18, read as follows: "Resident discharged home at 1140 with [family member-A]. [FM-A] and resident brought all personal belongings home with them. Vital signs at time of discharge were 126/57, 97.9, 69, 20 ,and 95% on RA [room air]. Resident was stable at time of discharge and had no concerns."

R32's medical record was reviewed and lacked any evidence a comprehensive discharge summary had been completed for R32 including a recapitulation of his stay including course(s) of treatment, medication reconciliation nor any evidence of a post-discharge plan of care being developed in coordination with R32 or his representatives.

During interview on 8/8/18, at 12:08 p.m. director of nursing (DON) stated R32 had an anticipated discharge; however, since he was there for respite care, the facility likely "didn't do one [discharge summary]." DON then added, "I do not know what you mean by a discharge

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F 661	Continued From page 26 summary. Do you mean like we do with a regular resident in the nursing home when discharged? No I don't have that." A previously employed social worker used to ensure a discharge form was completed and provided to residents or family members According to the DON, the form "should have been given to the [FM-A]." The DON stated that they would have talked to the resident and [FM-A] about a discharge plan, but acknowledged R32's medical record lacked any evidence that R32, [FM-A] or the physician had been communicated with regarding a discharge plan. During interview on 8/8/18, at 12:08 p.m. the director of clinical services (DOCS) stated there should have been an assessment done by the social worker upon resident discharge and a discharge summary for R32 should have been completed. A provided facility Discharge/Transfer of the Resident policy dated 6/2017, identified a discharge summary and post-discharge plan of care should be done "if the resident is discharged to another facility;" however, it did not include instructions for a discharge summary to be completed when a resident is discharged to their home.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		9/18/18

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Continued From page 27

Based on observation, interview and document review, the facility failed to ensure routine grooming-removal of facial hair for 1 of 5 residents (R24) who were assessed to be dependent on staff to meet grooming needs.

Findings include:

R24's face sheet included a medical diagnosis of dementia.

A Quarterly Minimum Data Set an assessment dated 6/15/18, stated that R24 requires "total assist" in all areas of care except for eating.

On 8/6/18, at 1:50 p.m. R24 was observed sitting at a dining table, and had obvious facial hair, about 1/4 of an inch long covering her entire chin, front, sides and underneath chin.

On 8/6/18, at 5:50 p.m. p.m. R24 was again observed in the dining room, and continued to have long facial hair.

On 8/7/18, at 12:03 p.m. R24 was seated in a living area of the facility, and still observed to have facial hair.

On 8/8/18, at 7:19 a.m. R24 was seated in the living area and had a large portion of her visible chin hair removed, however, a still visible patch of hair remained under her lower lip. At this time, licensed practical nurse (LPN)-A was interviewed about grooming for residents and stated, "We [staff] perform daily for men and PRN [as needed] for women. We check them daily." LPN-A reviewed R24's care plan and stated it instructed nursing staff to "observe for facial hair daily and shave as needed."

F 677

Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F677
Specific Resident: R24 Care Plan, Care Guide and assigned Tasks reviewed to ensure shaving is to be completed per resident preference. She has been being shaved as directed by her Care Plan.

Residents who require assistance with shaving have the potential to be impacted by this practice. Resident□s preference for removal of facial hair will be addressed

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F 677	Continued From page 28 During an interview in the afternoon of 8/8/18, nursing assistant (NA)-B explained they perform shaving hygiene on the residents' bath day which is usually once a week. NA-B also said that they would shave a resident if they "notice they need it" and then it is usually done with morning cares. When interviewed on 8/8/18, at 1:12 p.m. family member (FM)-A expressed R24 was generally "pretty well put together" in her life and would be upset about having chin "whiskers." Further, FM-A stated that the family had attempted to assist the facility to remedy the issue of unshaven facial hair by purchasing an electric shaver for R24's care. During an interview on 8/9/18, 2:45 p.m. director of clinical services (DOCS) was asked about following the care plan for shaving. DOCS responded that "following the care plan is a standard of practice."	F 677	as part of the admission process. Social Services will assist in acquiring razors to remove facial hair as necessary. DON or designee will provide re-education on grooming policy and procedure at 9/5 & 9/6 (NA) and 9/11 & 9/12 (Nurse) meetings. DON or designee will audit compliance with removal of facial hair through direct observation of 10% of facility population weekly x8 weeks, then bi-weekly x8 and then monthly x2 months. Results of audits will be presented at monthly QAPI meeting and recommendations/ changes implemented as necessary.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor to	F 684	Submission of this Response and Plan of Correction is not a legal admission that a	9/18/18

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F 684	Continued From page 29	F 684		

promote intact skin integrity and healing of skin damage on lower extremities for 1 of 3 residents (R20) reviewed for non-pressure ulcer related skin condition.

Findings include:

Observation of R20 on 8/9/18, at 9:28 a.m. R20 was located in her room. An attempt to interview R20 but R20 kept dosing off. There was a band aid on her right lower extremity.

On 8/9/18 at 2:23 p.m. R20 observed back in room with FM-K. FM-K stated she placed the bandaid on R20's leg yesterday because R20 was picking at a sore.

Observation and interview on 8/9/18, at 2:33 p.m. with licensed practical nurse (LPN)-D who assessed the wound on R20's lower extremities. When LPN-D observed the sores on the legs he stated, "I have a few concerns right off the bat." Family member (FM)-K was in the room at this time stated, "It is more red than I first saw on Thursday [8/2/18]." LPN-D said it could be infected in several spots on the lower right leg and the left leg does not have red spots around the scabs. LPN-D stated he would have a registered nurse (RN) look at the areas and assess and may have to call the provider to get orders to treat.

R20's 30 day assessment Minimum Data Set (MDS) an assessment dated 6/28/18, identified R20 had intact skin.

R20 current care plan lacked interventions to monitor skin integrity.

deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F684
Specific residents: R20 discharged 8/20/2018.

Residents who have skin alterations have the potential to be impacted by this practice. Care Plans for residents with wounds have been reviewed and revised as needed to reflect current skin condition.

Staff will be re-educated by the DON or designee on the process for identifying

F 684

Continued From page 30

R20's document reviewed titled, "skin review-weekly dated 7/22/18 and 7/29/18, identified skin intact.

R20's progress noted dated 7/20/18, indicated she had picked a sore on her right calf with a tweezers, will continue to monitor. On asking for other documentation regarding the ongoing monitoring of the sore on R20's calf, none was provided.

Review of R20's progress note dated 8/9/18, at 3:02 p.m. and authored by Licensed practical nurse (LPN)-D. Note read, "Lower extremities were viewed. Skin issues as follows: Right lower extremity; reddened circle about 10 cm [centimeter] above the ankle, anterior, 1 cm in diameter with 1 mm [millimeter] scab in the center; 2.8 cm x 1.8 cm reddened are with two scabs measuring 0.8 cm x 0.5 cm and 0.5 cm x 0.9 cm midway down from front left shin; four additional reddened areas with scabs inside reddened areas as follows: 0.5 cm x 0.2 cm scab inside 1.0 cm x 0.8 cm red circle; 0.8 cm diameter red area with two scabs each measuring 0.1 cm ; 1.0 x 0.7 cm w/2 mm scab; 0.8 cm diameter area with 3 mm scab within. Wounds cleansed and bacitracin applied. Continue to monitor for s/s of infection. If reddened areas do not show improvement, notify MD."

During an interview on 8/6/18, at 2:35 p.m. with family member (FM)-K indicated the facility told the family that R20 had picked her legs in multiple areas with a tweezers and FM-K had removed the tweezers.

On 8/9/18, at 12:31 p.m. licensed practical nurse

F 684

and reporting new skin conditions at 9/5 & 9/6 (NA) and 9/11 & 9/12 (Nurse) meetings.

In addition to weekly skin assessments currently being conducted, skin audits will be conducted by DON or designee for 10% of the facility population weekly x8 weeks, then bi-weekly x8 weeks and then monthly x2 months. Results of audit will be presented to QAPI Committee monthly and changes implemented as needed.

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F 684	Continued From page 31 (LPN)-D had been interviewed regarding R20's band aid and skin condition on legs. LPN-D stated skin is monitored during weekly showers, on admission and as needed. LPN-D added nursing assistants look at the resident's skin daily and they should report changes to the nurse. If there are significant changes to the resident skin, staff are to update physician. LPN-D stated he would expect documentation of the impaired skin in the progress notes especially if cares/treatments were given but it has not always done. On 8/9/18, at 1:55 p.m. director of clinical services (DOCS) indicated if skin concern is identified, the expectation is to monitor the skin concern at least weekly and then would expect to see a note documented in the progress notes. Requested incident reports involving skin- facility stated they had none. Requested policy on skin monitoring and none received.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		9/18/18

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F 688	Continued From page 32 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 2 of 4 residents (R7, R8) reviewed who had orders for hand splints. Findings include: R7's OT Progress note and Discharge Summary dated 3/27/18, indicated the discharge plans and instructions to nursing included daily bilateral upper extremity (BUE) ROM, bilateral palm protectors daily as tolerated, and to provide repositioning in a Broda chair (a tilt in space chair used for positioning). The notes indicated these instructions had been reviewed with facility staff and R7's family. R7's significant change Minimum Data Set (MDS) assessment dated 5/16/18, indicated R7 had severely impaired cognition, required total dependence for most activities of daily living (ADLs), had demonstrated no rejection of cares, had impaired ROM on both sides of upper and lower extremities, had a condition with a life expectancy of less than 6 months, and had received OT services from 2/18 to 3/27/18. R7's Order Summary Report signed by the medical provider on 7/3/18, indicated R7 was to	F 688	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F688 Resident Specific: R7 & R8 TAR, Care	

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F 688	Continued From page 33 utilize palm guards during the day which should be taken off at night. Directions indicated staff were to: wash the palm guards and allow them to air dry overnight, and to wash and dry R7's hands two times a day. R7's current care plan (no date), was requested and provided by facility nursing staff. The care plan identified R7's diagnoses to include: cerebral vascular accident (CVA) with hemiparesis (weakness on half of the body) of left non-dominant side, dementia without behavioral disturbances, contractures of: right and left shoulder, right and left elbow, and right and left hand, and muscle weakness. The care plan indicated on 5/22/18, R5 required assistance with ADLs with interventions including: apply bilateral palm guards per doctor's order, on during the day and off during the night, and PROM to bilateral arms daily. An undated nursing assistant care guide, indicated R7 was to have palm guards placed in the AM (morning) and removed at HS (hour of sleep). During observation on 8/6/18, at 3:44 p.m. R7 was in his bed on his back, wearing a blue t-shirt and covered with a green blanket. R7 had no palm guards or splints in place for his hands, and both hands appeared contracted. At 3:53 p.m. R7 was observed in the same position, still with no palm guards or splints in place. During this observation, palm guards were observed on top of R7's night stand. At 6:12 p.m. R7 was sitting in a Broda chair in the common room in front of the television (TV), he did not have any palm guards or splints in place in his hands.	F 688	Plan, Care Guide and assigned Tasks reviewed and updated to reflect orders for ROM and use of splints. Residents who require ROM or the use of splints have the potential to be impacted by this practice. Re-education to be provided by the DON or designee on 9/5 & 9/6 (NA) and 9/11 & 9/12 (Nurse) meetings by Aegis Therapy on Range of Motion and proper use of splints. Audits will be performed to ensure residents with orders for ROM or use of splints or similar devices are being performed. This will include residents with orders and will be conducted 2x/week x8 weeks, then once/week x8 weeks and then bi-weekly x8weeks and shall be conducted by DON or designee.	

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During observation on 8/7/18, at 8:27 a.m. R7 was sitting up to a dining room table seated in a Broda chair, receiving staff assistance with eating his breakfast. No palm guards were observed to be on either of R7's hands.

During observation on 8/8/18, at 7:23 a.m. R7 was sitting up to a dining room table seated in a Broda chair. R7 was wearing a blue t-shirt and had a blue blanket covering his lap. R7 had palm guards in place in both hands.

During interview on 8/8/18, at 2:05 p.m. OT-A stated, "[R7] has contractures in both hands and if you have contractures, the palm protectors are a soft way to keep the fingers away from the skin to prevent skin breakdown."

NA-F was interviewed by phone on 8/9/18, at 1:30 p.m. NA-F stated, "I am very familiar with [R7's] cares, I have worked here for almost 5 years. The night shift gets [R7] up in the morning, because we get up all of the residents who need two persons to assist with cares. We also put [R7's] palm guards on in the morning."

During interview on 8/9/18, at 4:18 p.m. the director of clinical services (DOCS) was uncertain whether staff were consistently using the hand splitns. The DOCS stated, I will have to investigate to see if staff have been consistently putting on the hand splints.
On 8/6/18 at 12:25 p.m., R8 was observed to have contractures of both wrists and hands. There were no splints or green roll (palm protector) in place during the observation.

On 8/7/18 at 9:15 a.m., R8 was observed seated in a Broda chair in her room. Again there was no

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F 688	Continued From page 35	F 688		

palm protector or splint in place in either hand. R8 was observed to have a Rooke boot (specialized protective supportive device for lower extremities) in place on her right heel, and her feet were elevated on a pillow.

On 8/8/18 at 7:16 a.m., R8 was observed sitting up in a Broda chair. There was no palm protector or splint in place. She was observed to have a Rooke boot on her right foot. At 8:15 a.m., R8 was observed sitting at the dining table being assisted by staff to eat breakfast. There was still no palm protector or splint in her hand.

On 8/9/18 at 9:00 a.m., R8 was observed sitting in her Broda chair wearing a Rooke boot on her left foot. A palm protector was observed in place on R8's left hand.

R8's face sheet indicated R8 had been readmitted to the facility three years ago, with diagnosis of dementia with behavioral disturbance and contracture of left hand.

R8's care plan printed on 8/9/18 included: "[R8] requires assistance with activities of daily living (ADLs) due to dementia with behavioral disturbances, osteoporosis, arthritis and contracture of left hand." Interventions included: "passive range of motion (PROM) and assistive active range of motion (AAROM) 2 x daily, left and right upper extremity, shoulder flexion, flex hand wrist x 15 repetitions as allowed. Replace green roll into her hand 6-8 hrs (hours), check skin, wash and replace." These interventions were identifed as having been initiated 4/20/17.

On 8/8/18, during interview at 12:30 p.m. Nursing assistant (NA)-C stated that R8 used to wear a

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palm protector but added, "I have not seen them for a while, not sure where they are at." NA-C was observed to move R8's right arm and to straighten R8's left fingers into an open position. Before leaving the R8's room, NA-C checked for the palm protectors and none were found.

On 8/8/18 at 12:41 p.m., licensed practical nurse (LPN)-A was interviewed regarding the left hand splint for R8. LPN-A said she had not seen R8 wear the splint for some time. LPN-A also checked R8's room for the palm protectors and none were found. At 1:14 p.m. LPN-A told the surveyor she had found R8's palm splint and had applied it.

On 8/9/18 at 8:39 a.m., an interview with the DOCS was conducted. The DOCS stated range of motion should be charted in the resident's treatment administration record (TAR). When reviewed, R8's TAR failed to include documentation of passive or assistive active range of motion having been completed over the past three months.

On 8/9/18 at 5:13 p.m., a message was left for the occupational therapy (OT) director regarding R8. The OT director responded by email indicating the palm guards/protectors were instituted primarily for hygiene purposes. The OT note further indicated R8 had been setup for a nursing range of motion program however, R8 had been resistive so the OT was unable to determine what would have happened, or whether things would have progressed in the time since R8 was last treated.

Although facility policies were requested related to PROM for dependent residents, and any

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F 688	Continued From page 37 occupational therapy policies, none were received.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe transfers were completed in accordance with the care plan for 1 of 1 resident (R24) reviewed who used a mechanical lift for transfers. Findings include: R24 face sheet included admission of 3/24/18, with diagnosis of lumbar compression fracture, history of falling, dementia with behaviors, muscle weakness and abnormal gait and mobility. On 8/6/18, 1:50 p.m. R24 had been observed to be sitting in a commons area of the facility in a broda chair (a chair used to assist persons in maintaining good body alignment when too weak to sit well independently). The sling of Hoyer lift (a mechanical lift that is used for persons who are unable to stand safely or bear weight) was noted to be under R24 in the broda chair. On 8/7/18, 12:03 p.m. observed R24 seated in	F 689	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition	9/18/18

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the dining room with the sling of Hoyer lift in place under her in broda chair.

On 8/7/18, 12:56 p.m. R24 was taken to her room by nursing assistant (NA)-A and licensed practical nurse (LPN)-A to use the commode for toileting. NA-A and LPN-A were observed to utilize a sit to stand lift (a mechanical lift used when a person has some ability to follow directions, bear weight to stand, and hold on to the lift handles) for transfer, and not a Hoyer lift. The sling for the Hoyer lift remained behind in R24's broda chair. Approximately 10 minutes later, after use of the commode, NA-A and LPN-A again used the sit to stand lift for transfer back to the broda chair; this time R24 was unable to stand upright with knees in a flexed position and upper body slid down in the sling with the sling pulling up against the underarm/shoulder region. NA-A noticed R24 had slid down in the sling and brought the broda chair over; however, because R24 was not standing upright, NA-A was unable to place the chair under R24's buttocks. NA-A tipped the chair up on the 2 front wheels and held it in a tipped position while LPN-A pushed the lift and R24 against the seat of the broda chair and NA-A then tipped the broda chair back so that R24 was seated in chair. Brakes were not applied on the mechanical lift or the broda chair during the transfer.

Immediately following the transfer, NA-A was interviewed about how staff knew which lift to use for R24. NA-A stated the care plan says to use a Hoyer with two people to transfer R24 to the bed and to use a bedpan but it has been "uncomfortable for her. She says it hurts." NA-A indicated that she planned to talk with the Director of Nursing (DON) because she thought the care plan hadn't been updated.

to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F689
R24 evaluated by therapy 8/9/2018, orders implemented and staff educated on safe transfers for that resident. Residents who require assistance with transfers with the use of mechanical sit to stand lifts have the potential to be impacted by this practice. Transfers for these residents will be observed by DON or designee and referrals made to therapy if indicated.

Nursing staff to be re-educated on how residents are to be transferred □ in accordance with Care Plans at 9/5 & 9/6 (RA) and 9/11 & 9/12 (Nurse) meetings.

Direct observation audits will be performed to ensure staff are transferring residents in accordance with their Care Plans. These audits will be performed by DON or designee 3x/week x 8 weeks, and then 2x/week x 8 weeks and then once/week x8 weeks.

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After the NA-A interview, LPN-A was interviewed about the choice of lift to be used during the observed transfer. LPN-A replied that they could use a sit to stand or Hoyer lift and would choose the sit to stand if the resident was capable. LPN-A indicated that staff would know this by looking at the care plan, "I'm pretty sure her care plan says Hoyer lift. We probably should have used a Hoyer, we just haven't gotten used to it...this putting her in bed to use a bed pan." LPN-A reviewed the medical record and verified that the care plan states that R24 "is dependent on Hoyer transfer, with sling left behind her while in wheel chair for safety." When asked about the transfer that had been observed at 12:56 p.m. LPN-A said that having to tilt the broda chair under R24 was "not safe" practice. LPN-A was able to locate a note from therapy dated 4/5/18, recommending that patient to be transferred with Hoyer, and use bed pan for toileting. No communication related to the use of a sit to stand lift versus a Hoyer lift was found by LPN-A.

During an interview on 8/7/18, 1:38 p.m. with physical therapy aide (PTA)-A said there were no recent recommendation made for R24 transfers and verified that the last therapy to nursing communication form was dated 4/5/18, and at that time they recommended that R24 should be "transferred using a Hoyer lift, and use of a bed pan for toileting."

During an interview on 8/7/18, 1:44 p.m. with LPN-B, she said that R24 was assessed as being "almost total assist" with transfers and the facility had to "go to use of a Hoyer lift for safety because she doesn't want to do anything for herself." When asked if therapy had been

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contacted recently about reassessment of R24's abilities, LPN-B said, "She probably wouldn't try [to work with therapist]."

Director of Nursing (DON) was also interviewed on the afternoon of 8/7/18 at approximately 2:00 p.m. about the observed transfer of R24 and she stated that it was the "personal preference" of R24 to use the commode instead of a bed pan because of difficulty emptying her bladder;" furthermore, DON indicated that the primary physician said that they could use the sit to stand instead of a Hoyer lift, but for toileting only. DON did state that a physician's order had just been received on 8/7/18 after the observed transfer at 12:56 p.m., and that the plan of care had just been updated. When asked to verify what the plan of care had stated at the time of the transfer, DON read "dependent on use of Hoyer with 2 assist, and use bedpan." The DON was asked about the process for advancing a resident from the use of a Hoyer lift (considered to be total assistance) to the use of a sit to stand (extensive, but not total assistance). The process was stated as follows, "have therapy re-evaluate the resident and then get orders." When asked if a recent therapy evaluation for a safe transfer using a sit to stand lift had been done, DON said, "the doctor doesn't always want people to go to therapy." When asked if a nursing assessment had been done for use of the sit to stand lift, the DON stated, "I work the floor at least three days per week and I've watched her many times." DON did say that a nursing assessment had not been done before calling the physician on 8/7/18. DON was advised of the observed transfer of R24 with the sit to stand lift and resident's inability to fully stand requiring staff to tilt chair on 2 wheels to reseat R24. When DON was asked if this

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F 689	Continued From page 41 sounded safe, the DON replied, "this is the first we heard that it wasn't safe. I was unaware that it wasn't okay." On 8/7/18, 3:08 p.m. observed DON evaluating R24's ability to use the sit to stand lift. At that time R24 was unable to follow DON's directions and the attempted use of the sit to stand was unsuccessful at that time--R24 was unable to stand. On 8/8/18, 7:24 a.m. in a follow up interview, DON stated, "We have suspended the use of EZ stand [brand name of a sit to stand lift]." Also said they had been in communication with therapy since being alerted to R24's weakness during transfer.	F 689		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		9/18/18

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§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure staff have the knowledge, competencies and skill sets to provide care and respond to each resident's individualized assessed needs safely and in a manner that promote each residents rights, mental and psychosocial well-being. This practice was evident for 1 of 5 registered nurses (RN-A); 3 of 18 nursing assistants (NA-A, NA-E & NA-H); and licensed practical nurse (LPN-A).

Finding include:

See 658: RN-A gave a "cocktail" of medications without verifying or documenting what medications made up the cocktail.
See 689: LPN-A and NA-A unsafe transfer without assessment completed.
See 880: LPN-A, NA-E and NA-H, had not performed hand hygiene during perineal cares to prevent the spread of infection.

During an interview with director of nursing (DON) on 8/7/18, at 11:54 a.m. revealed education and competencies were completed on all staff upon

F 726

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Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is

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F 726	Continued From page 43 hire and then annually. The staff completed a skills fair in August as well as demonstrations. DON said she started having staff come in the office to complete the requirements.	F 726	submitted as the facility□s credible allegation of compliance. F726 See Plan of Correction for F658 in regard to providing re-education to nurses on completing paper MAR when computer is unavailable. See Plan of Correction for F689 in regard to Plan of Correction on ensuring safe transfers are being performed on all residents in accordance with their Care Plans. See Plan of Correction for F880 in regard to hand washing and infection control education. In addition to the above, staff will continue to be educated on an ongoing basis. Education includes, but is not limited to: on hire, annually, at monthly meetings, as opportunities present themselves and on-line via Relias Training.	
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident choice	F 800	Submission of this Response and Plan of Correction is not a legal admission that a	9/18/18

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of preferred foods and foods were served according to physician orders for 1 of 1 resident (R5) who had an order for mechanical soft foods but received pureed consistency for entire meal and showed dislike for the pureed food.

Findings include:

R5's Admission Record dated 8/9/18, indicated an admit date of 6/22/15, and diagnoses of congestive heart failure (CHF), macular degeneration, legal blindness, and unspecified hearing loss.

R5's care area assessment (CAA) worksheet dated 9/5/17, indicated R5 to have blindness, visual problem that impedes ability to eat, hearing impairment in left ear and right ear is completely deaf. He had end stage congestive heart failure, shortness of breath and wears oxygen, required extensive to total assistance with all activities of daily living (ADLs).

R5's quarterly Minimum Data Set (MDS) an assessment dated 5/11/18, indicated moderate cognitive impairment, absence of useful hearing with no hearing aide, clear speech that is usually understood, severely impaired vision with no corrective lenses, no rejection of care identified. Further indicated R5 to need extensive assistance with eating, prognosis of life expectancy of less than 6 months, no swallowing disorder, weight 142 pounds, had a significant weight loss without a physician's ordered weight loss, and received a mechanically altered therapeutic diet.

R5's signed Physician's Orders dated 7/26/18, indicated R5 to receive a no added salt diet,

F 800

deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F800
R5 was identified to not have received foods per physician order and per his preference. R5□s diet order has been changed to better suit his needs and preferences.

Each resident residing within the facility has the potential to be affected if this requirement is not met.

WWHS nursing staff and HCSG staff have been re-educated to the requirement

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F 800	Continued From page 45 mechanical soft with pureed meats, and received a nutritional house supplement three times a day. R5's care plan dated, 7/10/15, Revised 3/1/17, R5 is at risk for oral problems related to being edentulous (without teeth), with an intervention to visit with him to obtain information on any food/beverage intolerances. Revised 8/17/17, he had a decline in intake eating ability, weight and skin integrity can be anticipated related to hospice status, with a goal to tolerate food texture and fluid consistency without choking episodes, and interventions to receive no added salt diet, mechanical soft with pureed meat, document meal intakes each meal, obtain and update food/beverage preferences, provide assistance with meals, provide food substitutes, weight monitoring per orders, and provide nutritional supplements per orders per family request. Revised 8/17/17, R5 is on hospice services through Season's Hospice related to terminal illness with a goal to be free from hunger, thirst and dry mouth, with an intervention for dietary to evaluate and modify meal and snack plan as needed. R5's Progress Notes dated 8/10/18, at 1:40 p.m. R5's weight warning was 123.1 lbs. Weight has been stable over the past week. Due to poor-fair intake and resident's requests for salt packet at times, requesting a D/C of NAS portion of the diet. Will communicate this preference to dietary/nursing staff and add to his meal ticket to offer this option when he dislikes the regular entrée served. During observation on 8/6/18, at 5:38 p.m. R5 is sitting up to the table in his Broda chair, a plate of pureed food sitting in front of him, and no attempt	F 800	and the identified area has been corrected. Nursing staff have been re-educated on offering food choices. Dietary staff have been re-educated on providing food textures consistent with the physician order. Audits will be completed on three (3) residents each week for four (4) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Dietary Manager or Designee is responsible party. Corrective action will be completed by 9/18/2018.	

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to feed self was observed. Licensed practical nurse (LPN)-B came and assisted R7 with eating. It was learned that R5 had had a cheese sandwich this week. At 5:40 p.m. LPN-B gets up and stands over the right side of R5, and asks if he would like something to eat. R5 responds, "That's why I am here." LPN-B asks R5, would you like rice or fish? R5 stated, "No!" LPN-B puts a bite of the pureed food in R5's mouth while standing over him, and stated would you like some milk? R5 stated, "Mm, hmm." LPN-B continued to stand over resident to his right and assist with drinking milk, offering pureed carrots. LPN-B then offered pureed chocolate cream pie, and R5 stated, "Oh that sounds good." At 5:49 p.m. LPN-B asks R5 if he would like more pie, and R5 stated, "No." LPN-B hands R5 a glass of milk and R5 drinks it independently. At 5:50 p.m. R5 was assisted with bites of his meal and a glass of milk. R5 was not offered any other food after he stated he did not want any fish. No one observed to offer R5 an alternate food choice. At 6:01 p.m. LPN-C asks LPN-B, what about R5? LPN-B stated, "Oh, he is done eating." At 6:06 p.m. R5 observed to drink half of his milk, and no further attempts from staff to assist with eating. At 6:14 p.m. R5 had been moved in his broda chair to the common area and set in front of the television.

During observation on 8/7/18, at 12:28 p.m. R5 asked LPN-B for a grilled ham and cheese sandwich. LPN-B stated, how about some cottage cheese? NA-E asks R5, "How about a piece of cheese?" R5 stated, "I want 3 slices." NA-E walks up to cook (C)-A tells her R5 asked for a grilled ham and cheese and then stated, we are probably past that, and then proceeds to tell (C)-A that R5 asked for 3 slices of cheese. (C)-A

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stated, did (R5) eat it the last time? NA-E stated, he ate 3 slices of cheese last time and (C)-A proceeds to put 2 pieces of cheese on a small red plate, and stated, "Here is 2 pieces." NA-E brings the plate of cheese to R5 and hands R5 a piece and R5 immediately starts eating the cheese without difficulty.

During interview on 8/7/18, at 12:32 p.m. when asked why R5 could not have a ham and cheese sandwich, LPN-B stated R5 has an order for mechanical soft diet, but his meat he likes pureed, so he would not be able to eat the sandwich. That is why we offered him the cheese. If he gets big pieces of meat in his mouth, he spits them out.

During observations on 8/9/18, at 12:02 p.m. R5 is sitting up to the table in the dining room in his Broda chair with his legs extended, wearing a blue t-shirt and a navy blue stocking hat. R5 has his eyes closed and his left hand on his chest. R5 appears very thin, has mouth hanging open and noted to have no teeth.

At 12:08 p.m. R5 attempted to sit up in his chair and yells, "Can I get to the bathroom quick, can I get to the bathroom quick, I am going, Oh I got to go!" NA-A removes R5 from the dining room to toilet him, and plate of food observed to be pureed. At 12:11 p.m. R5's meal ticket indicated diet to be mechanical soft-NAS pureed meats. Today's menu is 3 ounces (oz.) of ground roast beef, 2 oz. brown gravy, seasoned green beans, garlic mashed potatoes, dinner roll bread, butter, strawberry shortcake, milk, coffee or hot tea. All items on the plate are pureed including the dinner roll. At 12:14 p.m. R5 is brought back and pushed up to the table. NA-A hands R5 a glass

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F 800	Continued From page 48 of white milk and R5 is drinking it independently with his left hand. At 12:16 p.m. NA-A tells R5 what is on his plate: steak, mashed potatoes, and green beans. Further asked R5 what he would like to start with and R5 stated, "Steak." NA-A gives R5 a bite of the pureed roast beef and R5 stated, "That's steak? That's awful mushy!" NA-A stated, I know, and then stated to another staff at the table, "I don't think he liked that much." At 12:17 p.m. R5 observed to spit the bite of pureed roast in a napkin. NA-A encouraged R5 to take a drink of his milk to get the taste out of his mouth and R5 did. At 12:18 p.m. dietary manager (DM)-A was in the area and interviewed regarding R5's received all foods pureed and DM-A stated, his diet ticket says mechanical soft with the exception of the meat, meats should be pureed. At 12:20 p.m. NA-A gave R5 a bite of mashed potatoes, and R5 stated, that is not any better, can I have some salt?" NA-A stated he can't have salt because it says no added salt on R5's diet ticket. At 12:21 p.m. NA-E stated, "He honestly does not eat his meal usually, he just usually wants cottage cheese." When questioned if R5 was ever offered an alternate choice, NA-E stated, I think the alternate choice can be a grilled cheese sandwich. "He likes grilled cheese, but he can't eat it, he has a texture issue with food." At 12:23 p.m. DM-A was interviewed and said that R5's record was reviewed and he should be getting mechanical soft diet and found no documentation of why he would be getting a pureed diet. DM-A further verified a grilled cheese sandwich would be appropriate for his mechanical soft diet and is an alternate choice on the menu. DM-A stated, "We usually only assess what their food preferences are on admission." I am unaware of any documentation of it in his medical record. At 12:33 p.m. R5 was asked	F 800		

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what foods he liked and he stated he liked grilled cheese sandwiches. At 12:34 p.m. NA-E ordered R5 a grilled cheese sandwich and an apple juice after offering R5 a choice.

During interview on 8/9/18, at 12:37 p.m. R5 was asked how his appetite has been lately and R5 responded, "Well it's been good, I am still hungry, if that what you mean." R5 was questioned if he liked any of the pureed foods he was just given, he said, "No, it was mush, it was dog food." I like cheese, I am trying to think of what kind. I don't like limburger cheese, my step dad used to eat it, and my mother made him put it in the bathroom window. At 12:42 p.m. R5 was delivered a grilled cheese sandwich, LPN-B offered the plate to R5. R5 grabs a half slice of the grilled cheese and started eating it. When asked how the grilled cheese tasted, R5 stated it is good. There were no concerns with choking or chewing. At 12:44 p.m. NA-D stated R5 has been getting pureed diet since at least June of this year. Further stated, "I guess we never think to offer the alternate choice," I didn't think he would like it, we do offer him cottage cheese or cheese. At 1:18 p.m. R5 was sitting in his broda chair in his room, noted to have a couple bites of grilled cheese sandwich left in his hand. R5 stated, the sandwich was good and I am full. R5 smiled and stated, "I'll see you tomorrow."

During interview on 8/9/18, at 4:22 p.m. director of clinical services (DOCS) verified R5 never had a food preference assessment completed, so staff are unaware of R5's food preferences. DOCS stated, my expectation is, we should establish what a residents food preferences are on admission. We should try to get the resident to comply with their diet, but would look at risk and

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F 800	Continued From page 50 benefits if it was having a negative impact. DOCS stated, R5 has really declined in the last year since he was put on hospice. During phone interview on 8/10/18, at 1:22 p.m. DM-B stated, I am the dietary manager for the district, the facility is in the process of hiring a dietary manager right now, but I used to be the dietary manager there, so I know a lot of these residents. "I know you are probably calling about questions about (R5). DM-B verified all resident should have their food preference assessment completed on admission and verified R5 never had one completed. Further verified R5 has a mechanical soft and NAS diet order, has been receiving pureed foods, and has had a significant weight loss. DM-A stated, R5 should be able to have salt in his diet, as he is on hospice. Facility policy, Food Preferences, dated 5/14, indicated, It is the center policy that individual food preferences are identified for all residents, patients. The food service director or designee will complete a food preference interview within 72 hours of admission for the purpose of identifying individual food and beverage preferences. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on the diet order, allergies and intolerances, and preferences.	F 800		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		9/18/18

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F 880	Continued From page 51 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, failed to establish an on-going infection control program including a comprehensive analysis to identify possible patterns of infection within the facility. For program review 4 of 4 residents (R10, R30, R23 and R99) were reviewed for compliance. This deficient practice had the potential to affect all 29 residents residing in the facility. In addition, the facility failed to ensure current standards of practice of handwashing to prevent the spread of infection while providing peri-care for 3 of 3 residents (R24, 12 & R13) observed during cares.

Findings include:

INFECTION CONTROL PROGRAM:

F 880

Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.

Accordingly, the Facility has prepared and

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Review of the facility infection control surveillance log was completed and log was noted to contain monthly compellations of resident infections, associated laboratory results and treatment plans. A facility map identified where each resident with an infection resided during that month. The log also included a list of antibiotics used and for what types of infection. However, the monthly logs failed to include evidence that the listed information had been analyzed looking at transmission within the facility or facility response throughout the month or from month to month; nor was causal analysis completed. The surveillance log lacked commentary to show that the facility actively looked for correlations, trends or patterns related to the incidence of infection within the facility. Also there had been no evidence found or provided upon asking in regards to residents with signs or symptoms of an infection but not being treated with antibiotics were being monitored or actions were being taken to reduce the risk of the spread of infection.

Review of R10, R30, R23 and R99 randomly selected from the facility infection control surveillance log as having had infections was performed as follows:

R10's progress notes dated 2/28/18, showed resident had symptoms of urinary tract infection and after testing, Cipro an antibiotic was started, then changed to Bactrim an antibiotic. The medical record included no further evidence that symptoms were being monitored in response the treatment. On 3/2/18 progress note states that the Bactrim was discontinued and changed to Rocephin an antibiotic. Progress note fails to comment on the resident's condition and current signs or symptoms. A progress note dated 3/6/18,

F 880 (Plan of Correction)

submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.

F880
Specific Residents: R30 & R99 names not provided on Resident list. R10 & R23 reviewed medical record and both found to not have active infections.

Residents residing in the facility have the potential to be impacted by this practice. Ongoing tracking and real time analysis of tracking will be completed by the DON or designee to ensure potential patterns or potential outbreaks are identified and responded to in a timely manner.

Education will be provided to the IDT by the DON on the importance of tracking and analyzing information related to infections the week of September 3, 2018.

DON will analyze and trend data from Monthly Infection Control Log, Line Listing and map. The results of this information will be presented at monthly QAPI meeting and interventions implemented as necessary.

Infection Control Committee to meet at least quarterly to review and identify

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F 880	Continued From page 54 included that R10 was seen by physician and antibiotic was again ordered for urinary tract infection. No evidence of monitoring of symptoms was listed. R23's progress notes dated 5/14/18, showed evidence that resident had been complaining of urinary tract infection symptoms such as dysuria (painful urination), suprapubic pain (pain located over the bladder area) and urgency/frequency of urination. A urinalysis was done showing infection and R23 was started on Cipro an antibiotic on 5/14/18. The medical record failed to show any ongoing monitoring of resident symptoms or response to treatment until a progress note dated 5/31/18 showed resident again complained of symptoms of urinary tract infection, underwent testing and was started on Macrobid an antibiotic. R30's progress notes dated 4/3/18, showed evidence that resident had symptoms of respiratory infection, cough and sputum. R30 was seen by physician and started Augmentin an antibiotic on 4/3/18. The medical record failed to show any additional monitoring of the resident's symptoms or response to treatment other than noting an additional order for a bronchodilator on 4/7/18. R99's progress notes dated 6/21/18, showed evidence that resident had symptoms of respiratory infection on 6/21/18, including a productive cough and shortness of breath. Physician was notified and Augmentin an antibiotic Augmentin was ordered. The medical record failed to show any monitoring of symptoms on 6/22/18. On 6/23/18, progress note shows that family and caregivers opted for comfort care and medications were discontinued. Medical record	F 880	trends. Data will be used to implement interventions as necessary. The facility has developed and implemented effective 9/1/2018 a comprehensive surveillance tool. This tool identifies the resident, date of onset, type and site of infection, diagnosis, tests, x-rays, cultures performed for diagnosis, organism, treatment and interventions, whether the infection was health care associated, date infection resolved. Staff will be re-educated at 9/11 & 9/12 Nurse□s meeting to review Infection Prevention and monitoring residents□ vital signs as well as signs and symptoms specific to the body system affected by a resident with symptoms and/or an active infection. Specific Residents: R24, R12 & R13 medical records were reviewed and not found to have active infection. Residents have the potential to be impacted by this practice. The DON will provide staff education at 9/5 & 9/6 meeting on appropriate infection control procedures to include hand-washing. Audits will be performed by DON 4x/week x8 weeks, then 2x/week x8 weeks and then weekly x8 weeks to ensure staff are performing hand hygiene per policy.	

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showed no evidence of further monitoring of infection symptoms.

During an interview on 8/9/18, 2:45 p.m. director of clinical services (DOCS) indicated that R10, R23, R30 and R99 did not meet the professional expectations of monitoring
residents with infections in a nursing home. DOCS stated that documentation should show that nurses are assessing vital signs and symptoms of the infection specific to the body system affected, such as lung sounds for respiratory infections, urine odor or clarity for urinary infections. DOCS verified that the documentation in the aforementioned medical records did not show on-going monitoring of symptoms of infections. DOCS also reviewed the facility surveillance log and stated an expectation that the facility should have been doing a monthly analysis of data gathered. She further explained that they should look for and map clusters of infection so that they can associate interventions or initiate training. She verified that she did not find this documentation. When asked how they would know if the facility surveillance program was effective, she indicated that documentation of patterns and frequencies would help them to decide. She gave the example that noting an increase of urinary tract infections would indicate a problem so they would need to respond by taking some sort of action such as re-educating the staff in hand-washing. DOCS then said that they would know if this was effective by monitoring the data for improvement in infection rates after the intervention.

The facility utilizes Pathway Health Services Infection Control policy and procedures dated 2017 and provided a policy titled, "Infection

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Prevention and Control Program Manual Surveillance;" the policy stated that the program covers outcome surveillance activities that would require collecting, documenting and comparing data related to infections in order to identify clusters or trends; furthermore, the analysis would be used to identify "opportunities for improved care and process and identify an action plan for follow up and corrective action and reporting." The policy included instructions that said the facility should compare current and past infection control data and implement a correlating plan including goals and interventions to correct any noted problems.

HANDWASHING:

R24 had been observed on 8/7/18 at 12:56 p.m. when R24 was taken to room and a mechanical lift was used to assist onto a commode for toileting. Pants and incontinent briefs were wet and removed by certified nursing assistant, NA-A. At this time, NA-A did not remove soiled gloves and touched lift sheet (that is used for multiple people), the mechanical lift and multiple items in the environment with soiled gloves. After NA-A provided peri care, soiled gloves remained on while assisting R24 back to the chair. NA-A carried commode into the bathroom, touching the door handle. Gloves were removed and placed into trash bag and then the trash bag was taken to the soiled utility room across the hall without having washed hands. When NA-A came out from the soiled utility room, hand sanitizer was utilized. Licensed practical nurse (LPN)-A was present and assisted during the resident transfer to commode and failed to intervene. Immediately following the peri care NA-A was interviewed immediately after the transfer was done. When

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asked to explain proper hand hygiene protocol when assisting residents with personal cares, NA-A stated that they are supposed to wash before providing cares, then glove, then wash again after removing the gloves and when leaving the room. NA-A also said, "After I did peri-care, I took my gloves off after she sat down..I should have taken them off before." During the interview, NA-A verified that the lift, sling and environment were contaminated by her actions. Also, verified, was that she had received training in hand hygiene and the use of gloves since starting employment at the facility.

Facility records indicated that NA-A received training on hand hygiene 5/9/18, hand washing on 6/27/18, infection control essentials 5/12/18 and personal protective equipment on 7/4/18.

During an interview on 8/9/18, 2:45 p.m. DOCS states that they do observations and validation of hand hygiene skills for staff.

The facility utilizes Pathway Health Services Infection Control policy and procedures dated 2017 and provided a policy titled, "Infection Prevention and Control Program Manual Surveillance" which indicated the surveillance program should include process surveillance for practices directly related to resident care such as monitoring hand hygiene practices and proper use of personal protective equipment such as gloves. Also included the following statement related to hand hygiene, "The single most effective means of reducing the potential for MDRO [multi-resistant drug related organisms] is hand antisepsis before and after contact with residents, including after glove removal. Washing hands can accomplish hand antisepsis with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING ______ B. WING ______	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	525 BLUFF AVENUE ST CHARLES, MN 55972

(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 880	Continued From page 58	F 880		

antimicrobial soap and water or by using a waterless alcohol-based hand antiseptic."
R12 had been observed on 8/7/18, at 11:30 a.m. when nursing assistants (NA)-E and H were assisting R12 by transferring from her chair to the bed by a mechanical lift. Both NA-E and NA-H placed gloves on. Then NA-H removed soiled incontinence pad, used disposal wipes to clean peri-area, then placed clean incontinence pad on and transferred R12 back to her chair. Without changing soiled gloves NA-H was observed to handle the remote of the mechanical lift, adjust cushions and handles of the chair, and used the mechanical lift to transfer R12 in to the chair. Then NA-E removed her soiled gloves and placed them in her pants pocket. At 11:46 a.m. when NA-H removed the lift from the room. NA-H was asked about hand hygiene training. HA-H said she had left the soiled gloves on during the maneuvering of the equipment in the room and transferring of R12 from bed to the chair. Also NA-E was asked about hand hygiene practices and she said she placed her dirty gloves in her pocket because she was not sure where to place them and did not want to touch anything with dirty gloves on.

On 8/7/18, at 11:54 a.m. the director of nursing (DON) expected staff to remove soiled gloves and wash hands before touching the equipment. DON said staff are educated on hand washing upon hire and annually as well as a skills fair. DON said that staff have to complete demonstrations of hand hygiene and the reviews are kept in her office.
R13 had been observed on 8/7/18, at 10:25 a.m. when licensed practical nurse (LPN)-A had assisted to change R13's incontinence product and performing personal cares for R13. LPN-A

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F 880	Continued From page 59 took incontinence brief off R13, provided incontinence care by having wiped R13's perineal area with wipes, then wrapped wipes inside brief, placed brief on bed, after putting clean brief on R13 LPN-A grabbed soiled brief. Before leaving the room LPN-A still wearing the soiled gloves help cover R13 with blankets and adjusting pillows next to R13. LPN-A then removed soiled gloves and placed then in trash can, but did not wash hands. Shortly after removal of gloves LPN-A was observed to open a package that contained suction tubing which was used to suction oral secretions of the resident. LPN-A had not washed hands prior to opening the suction tubing. After leaving R12's room LPN-A, was asked about hand hygiene and she said she had not washed hands after removing soiled gloves used to complete perineal care for R13. LPN-A then went into R13's bathroom and washed hands before providing more services.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain an airconditioner unit used in the kitchen in a state of good repair. Findings include: Observation on 8/6/18, at 12:03 p.m. Cook-A serving supper from a stem table placed under a ceiling heating, ventilation and air conditioner	F 908	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	9/18/18

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F 908	Continued From page 60 (HVAC) unit. The HVAC noted to have droplets of moisture surrounding the outer perimeter of the square unit. There was an oval shape collection tray made of PVC (polyvinyl chloride-used in plumbing) piping secured to the HVAC which was observed to only collect a few drops of moisture coming from the unit. There was a filter visibly covered in dust, grease build up. On 8/7/18, at 4:17 p.m. Cook-B stated the HVAC has been cleaned a lot lately due to grease, dirt, grim and water dripping. Cook-B indicated the droplets drip down and they call maintenance and they come in to clean the unit. Cook-B added the center piece (filter) is new and was not there before a couple months ago During an interview on 8/8/18, at 7:25 a.m. the maintenance director said he noticed a few months ago the HVAC unit needed to be cleaned due to dirty water dripping and added a filter at that time. Maintenance indicated the system has not been checked by a licensed HVAC company but trying to do trial and error to maintain. Maintenance verified the collection tray under the unit did not completely collect all the condensation drops due to the tray not fitting the HVAC unit. Policy review titled Infection Prevention and Control Manual-Dietary dated 2017 reads; The Dietary Department will be maintained in a clean and sanitary manner to prevent foodborne illness.	F 908	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F908 A new drip pan will be placed under the HVAC in kitchen by 9/18/2018. Audit drip pan weekly x24 weeks to ensure condensation drops are being collected properly.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		9/18/18

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F 921	Continued From page 61 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an environment that was safe and clean for 2 of 2 resident rooms (RR107B and RR301) observed during facility tour. Findings include: On 8/6/18 at 1:31 p.m. RR107B, heat register located behind the bed had rusted areas and the cover was broken. At 3:02 p.m. review of RR301 bathroom noted to have dark brown staining on floor around toilet. Resident does not currently used bathroom. During tour and interview with maintenance director (MD)-A on 8/9/18 at 9:00 a. m., MD-A stated that he would look at rooms for general maintenance concerns when residents were discharged. Then he would complete repairs and paint before new resident is admitted to that room. During tour RR107B had been noted to have missing areas of paint on walls and heat register fins were broken. In addition, during tour noted bathroom floor in RR301 had a dark brown ring around toilet. MD-A stated that he will need to replace the wax ring, and see what needs to happen with the flooring around it. MD-A stated that on 6/22/18, he had caulked around toilet due to a leak and that the brown stains were not present at that time. He said, "That's bad and will need to be fix." MD-A then said there is a maintenance book located at the nursing stations that staff use to let me know of things that need to be fixed. There has been nothing written in them for awhile.	F 921	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F921 A new ring will be placed under the toilet in RR301 by 9/18/2018. RR107 will have touch-up paint completed by 9/18/2018.	

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F 921	Continued From page 62	F 921	Audits will be performed on five registers/week x8 weeks then four registers/week x8 weeks and then 2 registers/week x8 weeks to ensure they are functioning properly.	

F5270026

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

PRINTED: 09/10/2018
FORM APPROVED
OMB NO. 0938-0391

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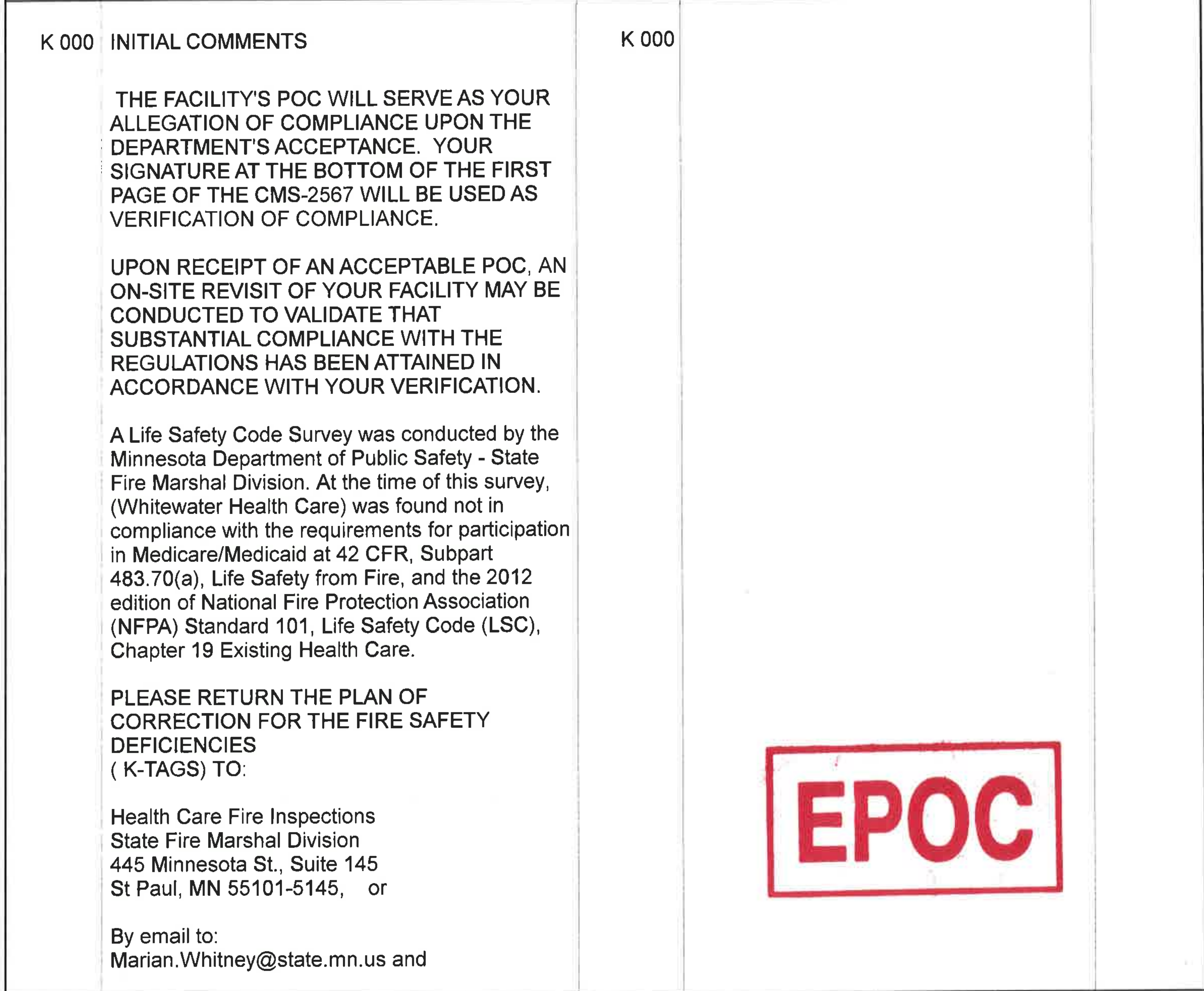

K 000 INITIAL COMMENTS — K 000

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, (Whitewater Health Care) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

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

By email to:
Marian.Whitney@state.mn.us and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/05/2018

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

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K 000	Continued From page 1	K 000		

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.

Whitewater Health Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1967, with a partial basement and was determined to be of Type II(111) construction. In 1969, an addition was constructed to the West Wing that was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 55 beds and had a census of 30 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2018, observations and staff interview revealed the following: Observation during the walk-through inspection revealed high storage in the following area of the facility: (1) Basement - Physical Therapy (2) Basement - Staff Break Rm - Storage #4	K 351	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	9/18/18

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K 351	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. K351 Areas of concern were high storage in the Physical Therapy closet and staff breakroom storage #4. All occupants within the facility could potentially be affected if this requirement is not met. Staff have been re-educated on keeping storage below the red line and keeping storage 18 away from the sprinkler heads. Maintenance Director has been re-educated to the requirement and the identified has been corrected. Audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI. Areas of concern will be corrected immediately. Maintenance Director or Designee is	

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K 351	Continued From page 4	K 351	responsible party. Corrective action will be completed by 9/18/2018.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This **REQUIREMENT** is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2018, observations and staff interview revealed the following: Observation during the walk-through inspection revealed kitchen appliances connected to a power strip: Basement - Staff Break Rm Observation during the walk-through inspection	K 511	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and	9/18/18

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K 511	Continued From page 5 revealed an unsecured electrical panel in the resident corridor adjacent to the facility Dining Rm This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. K511 Areas of concern were electrical panel adjacent to facility dining room was unsecured. Kitchen appliances connected to power strip in basement staff breakroom. All occupants within the facility could potentially be affected if this requirement is not met. Educate staff that appliances cannot be connected to a power strip. Remove power strip from staff breakroom. Lock electrical panels in resident areas. Maintenance Director has been re-educated to the requirement and the identified has been corrected. Audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month.	

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K 511	Continued From page 6	K 511	Audits will be reviewed at QAPI. Areas of concern will be corrected immediately. Maintenance Director or Designee is responsible party. Corrective action will be completed by 9/18/2018.	9/18/18
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2018, observation and documentation reviewed revealed the following:	K 712	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	525 BLUFF AVENUE ST CHARLES, MN 55972

(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 712	Continued From page 7 Documentation review revealed that fire drills were not conducted for: Q1 - 3rd shift; Q2 - 2nd shift; Q3 - 3rd shift This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. K712 Fire drills were not conducted for: Q1-3rd shift; Q2-2nd shift; and Q3-3rd shift. All occupants within the facility could potentially be affected if this requirement is not met. Spreadsheet was created to document fire drills completed on each shift. Maintenance Director has been re-educated to the requirement and the identified area has been corrected. Audits will be completed each quarter, ensuring that fire drills are completed on each shift. Audits will be reviewed at QAPI. Areas of concern will be corrected immediately. Maintenance Director or Designee is	

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	245270	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2018

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K 712	Continued From page 8	K 712	responsible party. Corrective action will be completed by 9/18/2018.	
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This **REQUIREMENT** is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2018, observation and documentation reviewed revealed the following: Documentation review revealed that fire door inspection had not been completed.	K 761	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set	9/18/18

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

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OMB NO. 0938-0391

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**08/22/2018**

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WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE** **ST CHARLES, MN 55972**

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K 761	Continued From page 9 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 761	forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. K761 Fire doors were not inspected annually. All occupants within the facility could potentially be affected if this requirement is not met. Annual fire door inspection has been added to the Facility□s Preventative Maintenance Program and will automatically alert staff when completion is required. Inspection log has been created to document annual fire door inspection. Maintenance Director has been re-educated to the requirement and the identified area has been corrected. Maintenance Director or Designee is responsible party. Corrective action will be completed by	

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K 761	Continued From page 10	K 761	9/18/2018.	
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2018, observation and documentation reviewed revealed the following: Documentation review revealed that a space heater policy available for review and assessment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 781	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is	9/18/18

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K 781	Continued From page 11	K 781	submitted as the facility□s credible allegation of compliance. K781 Space heater policy was not available for review and assessment. Review and make available company space heater policy. All occupants within the facility could potentially be affected if this requirement is not met. Maintenance Director has been re-educated to the requirement and the identified area has been corrected. Maintenance Director or Designee is responsible party. Corrective action will be completed by 9/18/2018.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6,	K 914		9/18/18

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K 914	Continued From page 12 which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 08/22/2018, observation and documentation reviewed revealed the following: Documentation review revealed that electrical outlet testing had not been completed. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance.	

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K 914	Continued From page 13	K 914	K914 Electrical outlet testing was not completed. Annual electrical outlet testing has been added to the Facility□s Preventative Maintenance Program and will automatically alert staff when completion is required. A log has been created to document the annual electric outlet test. All occupants within the facility could potentially be affected if this requirement is not met. Maintenance Director has been re-educated to the requirement and the identified area has been corrected. Maintenance Director or Designee is responsible party. Corrective action will be completed by 9/18/2018.	