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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 40YO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/30/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(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 :
Jana Bromenshenkel, HFE NEII 01/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/13/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/11/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245368

January 13, 2016

Mr. Kyle Hedlund, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

Dear Mr. Hedlund:

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

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

Effective December 16, 2015 the above facility is certified for:

119 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 119 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2016

Mr. Kyle Hedlund, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368026

Dear Mr. Hedlund:

On November 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2015. 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 December 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2015 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 November 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2015, effective December 16, 2015 and therefore remedies outlined in our letter to you dated November 20, 2015, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245368	A. Building B. Wing	12/30/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **12/15/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/15/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/15/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	01/10/2016	32601	12/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245368	A. Building B. Wing	12/30/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/15/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/15/2015**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	01/10/2016	32601	12/30/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245368	01 - MAIN BUILDING 01	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0022	Correction Completed **12/16/2015**	ID Prefix Reg. # **NFPA 101** LSC K0050	Correction Completed **12/16/2015**	ID Prefix Reg. # **NFPA 101** LSC K0056	Correction Completed **12/16/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	01/10/2016	27200	12/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/4/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245368	02 - SUB ACUTE	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	12/16/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/mm	Date: 01/10/2016	Signature of Surveyor: 27200	Date: 12/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/4/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2016

Mr. Kyle Hedlund, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

Re: Reinspection Results - Project Number S5368026

Dear Mr. Hedlund:

On December 30, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2015, with orders received by you on November 24, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

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

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00298	A. Building B. Wing	12/30/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **12/15/2015**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **12/15/2015**
ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **21025** Reg. # **MN Rule 4658.0615** LSC	Correction Completed **12/15/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **12/15/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **12/15/2015**
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp.** LSC	Correction Completed **12/15/2015**	ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **12/15/2015**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **12/15/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	01/10/2016	32601	12/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00298	A. Building B. Wing	12/30/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21995** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **12/15/2015**				

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	01/10/2016	32601	12/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/6/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 40YO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/06/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(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 :
Yvonne Switajewski, HFE NEII — 12/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/10/2015 (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
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Electronically delivered
November 20, 2015

Ms. Susan Johnson, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368026

Dear Ms. Johnson:

On November 6, 2015, 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. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

<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 a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 December 16, 2015, 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 December 16, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 February 6, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

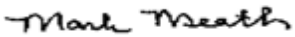
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

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

Sincerely,



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		12/15/15

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

Electronically Signed | 12/01/2015

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

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency and thoroughly investigate incidences of possible mistreatment related potential sexual misconduct for 1 of 3 incident reports reviewed and for 1 of 2 residents (R148, R145) who were involved with potential sexual misconduct. Findings include: R148's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R148 was diagnosed with dementia, anxiety disorder, depression and seizure disorder. The MDS also indicated R148 had severe cognitive impairment, required extensive assist for activities of daily living and supervision - limited assistance of one staff while ambulating. The MDS also indicated R148 displayed physical aggression towards other 1-3	F 225	Corrective Action- OHFC has been notified of the potential sexual misconduct of residents 148 and 145. Corrective Action as it applies to other residents- all residents have the potential to be effected by this deficient practice. An audit has been completed to assure that any potential sexual misconduct between residents has been investigated and reported as appropriate. Date of Completion: December 15th, 2015 Recurrence will be prevented by: Staff members have been educated on what is reportable to OHFC and that the report needs to be completed immediately, with the investigative report following within 5 days. Random audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The QAPI committee will determine when the audits	

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F 225	Continued From page 2 days and wandering behaviors 4-6 days during the MDS assessment period. R148's The Activities of Daily Living Care Area Assessment (CAA) dated 12/29/14, indicated R148 was able to ambulate independently without any type of assistive device and she was at risk for falls. R148's Cognition CAA dated 12/29/15, indicated R148 was diagnosed with dementia and was at risk for further cognitive decline due to disease progression. R148 had difficulty communication wants/needs to others and the staff were to anticipate her needs. R148's care plan dated 12/26/14, indicated R148 was at risk for falls, wandered throughout the nursing unit and was unable to remove herself from harm. The care plan directed staff to intervene and separate resident as safety concerns were identified, to ensure R148 was not alone with R145 and to keep the environment safe. R145's quarterly MDS dated 8/6/15, indicated R145 was diagnosed with chronic obstructive pulmonary disease and had moderate cognitive impairment. The MDS indicated R145 required extensive assistance with activities of daily living and had not displayed dementia or mood/behavior indicators. R145's care plan dated 3/31/15, identified a	F 225	may be discontinued. Corrective Action will be monitored by: DON or Designee	

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F 225	Continued From page 3	F 225		

concern related to R145 attempting to have intimacy / courtship behaviors directed towards female residents residing in the community. The goal was to prevent courtship behaviors with the unidentified female resident as it was "nonconsensual."

Review of R148's Progress Notes revealed the following:

-On 3/17/15, at 3:45 p.m. R148 was found in the Rivers Community seated next to R145 (a male resident with dementia). R145 had his hand down R148's pants. The staff members separated the residents and directed the staff to continue to monitor R148's whereabouts and intervene as necessary. The facility did not complete an incident report, complete a thorough investigation nor reported it to the State Agency, as required.

On 11/4/15, at 12:00 p.m. family member (FM)-A stated R148 had increased wandering in the past year. She stated she was aware R148 entered other resident rooms and often picked up items that did not belong to her. She stated the facility staff kept an eye on R148 as best as possible. FM-A did not express any concerns related to inappropriate sexual touch.

On 11/4/15, at 12:48 p.m. licensed practical nurse (LPN)-I stated R148 wandered around the Lakes Neighborhood and at times would have altercations with other residents. She stated when that happened, the residents were separated. LPN-I stated if she had noticed

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F 225	Continued From page 4	F 225		

concerns with the residents, the residents would be separated. She stated she was aware of R148 being involved with resident to resident altercations, but had not observed any of the alleged incidences.

On 11/4/15, at 1:02 p.m. activity aide (AA)-A stated R148 continuously wandered and paced on the unit. AA-A stated she did not feel R148 disrupted other residents and when she noticed R148 wandering, she tried to engage R148 in a one to one activity.

On 11/4/15, at 1:22 p.m. nursing assistant (NA)-H stated R148 wandered daily. She stated R148 did not seem to be afraid of any of the other residents nor did the other residents seem to be afraid of R148. She stated she separated the residents if she saw a concern.

On 11/4/15, at 1:40 p.m. licensed social worker (LSW)-A stated she had not been made aware of any concerns related to resident to resident concerns on the Lakes Neighborhood. Therefore, was unaware of any investigations that may have taken place.

On 11/5/15, at 12:06 p.m. registered nurse (RN)-A stated the altercations involving R148 occurred with other residents with dementia therefore, the residents were just to be observed and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed because R148 had not attempted to open the doors which

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F 225	Continued From page 5	F 225		

decreased the behaviors with some of the male residents (R145). RN-A stated the facility had not put any other interventions in place to increase the supervision on the Lakes Neighborhood.

On 11/5/16, at 12:14 p.m. LSW-A stated the facility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations and ensure resident safety. LSW-A stated the only new intervention implemented was to close the doors between the two dementia units.

On 11/5/15, at 12:17 p.m. the director of nursing (DON) stated the facility had provided staff members education regarding approaching residents with dementia. She stated the activity staff and the kitchen staff had also received training so they could assist with the residents as needed.

The undated Abuse Prevention Plan directed staff to immediately report all suspected maltreatment / mistreatment to the State Agency. The plan indicated resident to resident altercations would be reportable if the residents acted "willfully."

On 11/5/15, at 2:05 p.m. LSW-A stated the facility was to report any concerns related to resident to resident potential sexual misconduct if the residents were seeking each other out. LSW-A stated R148 and R145 had sought each other out as they were not involved with sexual misconduct with any other residents. LSW-A verified the incident as noted above should have been

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F 225	Continued From page 6 investigation and reported to the State Agency as directed by the policy.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy and procedures related to investigating and reporting incidences of potential resident to resident sexual misconduct to the State agency for 1 of 3 incidences reviewed and for 1 of 2 residents (R145, R148) reviewed for abuse and neglect. Findings include: The facility's undated Abuse Prevention Plan directed staff to report all suspected maltreatment / mistreatment immediately to the State agency. The plan identified resident to resident altercations would be reportable if the residents acted "willfully." R148's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R148 was diagnosed with dementia, anxiety disorder, depression and seizure disorder. The MDS also indicated R148	F 226	Corrective Action- OHFC has been notified of the potential sexual misconduct of residents 148 and 145. Corrective Action as it applies to other residents- all residents have the potential to be effected by this deficient practice. An audit has been completed to assure that any potential sexual misconduct between residents has been investigated and reported as appropriate. Date of Completion: December 15th, 2015 Recurrence will be prevented by: Staff members have been educated on what is reportable to OHFC and that the report needs to be completed immediately, with the investigative report following within 5 days. Random audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	12/15/15

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F 226	Continued From page 7 had severe cognitive impairment, required extensive assist for activities of daily living and supervision - limited assistance of one staff while ambulating. The MDS also indicated R148 displayed physical aggression towards other 1-3 days and wandering behaviors 4-6 days during the MDS assessment period. R148's The Activities of Daily Living Care Area Assessment (CAA) dated 12/29/14, indicated R148 was able to ambulate independently without any type of assistive device and she was at risk for falls. R148's Cognition CAA dated 12/29/15, indicated R148 was diagnosed with dementia and was at risk for further cognitive decline due to disease progression. R148 had difficulty communication wants/needs to others and the staff were to anticipate her needs. R148's care plan dated 12/26/14, indicated R148 was at risk for falls, wandered throughout the nursing unit and was unable to remove herself from harm. The care plan directed staff to intervene and separate resident as safety concerns were identified, to ensure R148 was not alone with R145 and to keep the environment safe. R145's quarterly MDS dated 8/6/15, indicated R145 was diagnosed with chronic obstructive pulmonary disease and had moderate cognitive impairment. The MDS indicated R145 required extensive assistance with activities of daily living	F 226		

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F 226	Continued From page 8 and had not displayed dementia or mood/behavior indicators. R145's care plan dated 3/31/15, identified a concern related to R145 attempting to have intimacy / courtship behaviors directed towards female residents residing in the community. The goal was to prevent courtship behaviors with the unidentified female resident as it was "nonconsensual." Review of R148's Progress Notes revealed the following: -On 3/17/15, at 3:45 p.m. R148 was found in the Rivers Community seated next to R145 (a male resident with dementia). R145 had his hand down R148's pants. The staff members separated the residents and directed the staff to continue to monitor R148's whereabouts and intervene as necessary. The facility did not complete an incident report, complete an investigation or reported it to the State Agency. On 11/4/15, at 12:00 p.m. family member (FM)-A stated R148 had increased wandering in the past year. She stated she was aware R148 entered other resident rooms and often picked up items that did not belong to her. She stated the facility staff kept an eye on R148 as best as possible. FM-A did not express any concerns related to inappropriate sexual touch. On 11/4/15, at 12:48 p.m. licensed practical nurse (LPN)-I stated R148 wandered around the Lakes	F 226		

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F 226	Continued From page 9	F 226		

Neighborhood and at times would have altercations with other residents. She stated when that happened, the residents were separated. LPN-I stated if she had noticed concerns with the residents, the residents would be separated. She stated she was aware of R148 being involved with resident to resident altercations, but had not observed any of the alleged altercations.

On 11/4/15, at 1:02 p.m. activity aide (AA)-A stated R148 continuously wandered and paced on the unit. AA-A stated she did not feel R148 disrupted other residents and when she noticed R148 wandering, she tried to engage R148 in a one to one activity.

On 11/4/15, at 1:22 p.m. nursing assistant (NA)-H stated R148 wandered daily. She stated R148 did not seem to be afraid of any of the other residents nor did the other residents seem to be afraid of R148. She stated she separated the residents if she saw a concern.

On 11/4/15, at 1:40 p.m. licensed social worker (LSW)-A stated she had not been made aware of any concerns related to resident to resident concerns including the sexually related incidents on the Lakes Neighborhood. Therefore, was not aware if an investigation had been completed.

On 11/5/15, at 12:06 p.m. registered nurse (RN)-A stated the altercations involving R148 occurred with other residents with dementia therefore, the residents were just to be observed

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and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed because R148 had not attempted to open the doors which decreased the behaviors with some of the male residents (R145). RN-A stated the facility had not put any other interventions in place to increase the supervision on the Lakes Neighborhood.

On 11/5/16, at 12:14 p.m. LSW-A stated the facility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations and ensure resident safety. LSW-A stated the only new intervention implemented was to close the doors between the two dementia units.

On 11/5/15, at 12:17 p.m. the director of nursing (DON) stated the facility had provided staff members education regarding approaching residents with dementia. She stated the activity staff and the kitchen staff had also received training so they could assist with the residents as needed.

On 11/5/15, at 2:05 p.m. LSW-A stated the facility was to report any concerns related to resident to resident potential sexual misconduct if the residents were seeking each other out. LSW-A stated R148 and R145 had sought each other out as they were not involved with sexual relations with any other residents. LSW-A verified the incident as indicated above, should have been investigated and reported to the State agency as directed by their policy.

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F 278	Continued From page 11	F 278		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded to reflect the resident's range of motion (ROM) status for 1 of 5 residents (R23) reviewed	F 278	Corrective Action- R 23 has been re-assessed for ROM needs and the care plan has been updated accordingly. The MDS has been reviewed and corrected to appropriately reflect the resident needs.	12/15/15

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F 278	Continued From page 12 for ROM. Findings include: R23's quarterly MDS dated 9/29/15, indicated R23 was diagnosed with dementia and had severe cognitive impairment. The MDS also indicated R23 required total assistance with all activities of daily living and had limited range of motion on one side of her upper body. R23's annual MDS dated 6/29/15, also indicated R23 had limited ROM on one side of her upper body. The Activities of Daily Living Care Area Assessment (CAA) was not required following this MDS. R23's Nursing Assessment dated 9/28/15, indicated R23 had limitations in ROM on one side of her upper body and had no limitations in her lower extremities. On 11/4/15, at 7:08 a.m. nursing assistant (NA)-F and NA-H were observed to transfer R23 from bed into a chair via a mechanical lift. R23's hands were observed to remain in a closed (loose) fisted position. R23 was not observed to move her arms or her legs independently during the transfer. -At 7:15 a.m. NA-H was observed to apply a sweater and bilateral sleeve protectors to R23's arms. R23 did not assist nor were R23's shoulders and elbows observed to extend to assist with the application of the sweater and R23's hands remained in a closed position. -At 7:53 a.m. NA-F was observed to totally assist	F 278	Corrective Action as it applies to other residents- All residents with ROM needs have the potential to be effected by this deficient practice. An observational audit was conducted and any residents with on-going ROM needs have been assessed to assure that they are receiving the appropriate care. Care plans and MDS□s have been updated as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to assess and treat residents with ROM needs. Staff members have been educated on the need to complete MDS□s accurately according to resident needs and to assure accuracy of care plans. All staff educational meetings were held on November 30, 2015 . Random ROM observational audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and DON are responsible for these audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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R23 to eat the breakfast meal. R23 was observed to be unable to independently move her upper extremities.
-At 9:15 a.m. NA-G and NA-F were observed to transfer R23 from the chair to bed via a mechanical lift. Once in bed, R23 received assistance with incontinence cares. R23's knees were slightly bent with her legs observed to remain clamped together during the cares. R23's feet were observed to be in a pointed downward position (foot drop). R23 was not observed to participate with the cares.

On 11/4/15, at 1:10 p.m. activity aide (AA)-A stated R23 received passive ROM six days a week during activities. She stated the activity staff completed arm and leg repetitions for about 20 minutes each day. She stated R23's arms and legs had been "tight" but they were much better and R23 appeared stronger after receiving the assistance with ROM.

On 11/5/15, at 6:10 a.m. NA-G was observed to provide morning cares for R23. NA-G was able to open R23's left hand to wash it and was able to move R23's left shoulder slightly to wash under it. The left elbow did not extend during cares. NA-G was able to open R23's right hand, but R23's fingers did not extend past 90 degrees. R23's right elbow did not extend and the right shoulder was able to be moved in order for NA-G to wash under the right arm.
NA-G stated R23's upper extremities were unable to be fully extended.
-At 6:15 a.m. NA-H entered the room to assist with cares. NA-H and NA-G were observed to complete R23's lower body cares. R23's feet

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F 278	Continued From page 14 remained in a pointed downward position (foot drop) as staff applied R23's socks. R23's legs were observed to remain together and slightly bent at the knees as the NAs completed perineal cares and applied R23's pants. NA-H stated R23's legs had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move her arms and legs. NA-H stated R23's ROM abilities had not changed in the past year. On 11/5/15, at 9:20 a.m. registered nurse (RN)-D stated she completed the MDS but did not perform ROM exercises on dependent residents. She stated all MDS coding was transcribed from the Nursing Assessment documentation completed by RN-A. -At 9:25 a.m. RN-D was observed to perform ROM for R23 while R23 was in bed. RN-D stated R23 displayed limitations in ROM ability in bilateral shoulders, elbows, hands, hips, knees and feet. -At 9:40 a.m. RN-D verified R23's MDS was not coded correctly as it did not identify R23's limitations in ROM in both the upper and lower extremities. At this same time, RN-A confirmed she had completed R23's 9/28/15, Nursing Assessment form and had indicated R23's ROM limitations were to just one side of her body. On 11/5/15, at 2:20 p.m. RN-A stated the identified concerns related to R23's limited ROM were all new since 9/28/15. On 11/6/15, at 8:30 a.m. RN-C verified RN-D did	F 278		

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not perform ROM exercises in order to determine a residents' ROM abilities, rather, was to complete the MDS according to the Nursing Assessment documentation. RN-C verified the Nursing Assessment completed on 9/28/15, was the assessment RN-D would have referred to when completing the quarterly MDS as indicated above. RN-C stated RN-D would only go onto the nursing units to review resident areas of concern only if the documentation contraindicated itself. RN-C stated RN-D was not expected to complete ROM for R23 prior to the completion of an MDS.

On 11/6/15, at 8:42 a.m. RN-D stated she had located R23's past therapy evaluations. R23's Physical Therapy Evaluation dated 3/27/13, identified R23 had limitations in ROM bilaterally in the lower extremities including hips, knees and feet. A passive ROM program was established 6/28/14, at which time R23 was identified with bilateral limitations in her shoulders, arms and hands. RN-D verified R23's MDS was not coded correctly.

The Resident Instrument Assessment (RAI) instruction manual used for the completion of the MDS, dated 4/2012, indicated the RN completing the MDS should comprehensively assess the residents ability to perform ROM by either verbally directing the resident to complete a task, or physically assisting the resident with the movements by supporting his or her extremity and guiding it through the joint ROM. In addition, the RAI manual, indicated by signing the MDS as complete, the RN was certifying that the information entered on the MDS, to the best of their knowledge, most accurately reflected the resident's status.

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F 279 SS=D	Continued From page 16 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan to include a restorative nursing range of motion (ROM) program for 1 of 1 resident (R72) reviewed for ROM and for 1 of 1 resident (R203) in the sample who required assistance with ambulation, Findings include: R72's annual Minimum Data Set (MDS) dated	F 279	Corrective Action- R 203 has been re-assessed and an ambulation plan has been put in place. R 72 has been re-assessed and an ROM plan has been put in place. The care plans have been updated. Corrective Action as it applies to other residents- All residents with ambulation or ROM needs have the potential to be effected by this deficient practice. An audit was conducted and any residents with ambulation or ROM needs have been	12/15/15

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F 279	Continued From page 17 9/17/15, indicated R72 was diagnosed with dementia, osteoarthritis and had severe cognitive impairment. The MDS indicated R72 did not walk and had limitations in ROM to both lower extremities. R72's medical record note dated 9/5/15, by registered nurse (RN)-B indicated a new restorative program for the nursing assistants to complete was initiated. The restorative program included passive range of motion six times per week, provide abduction, adduction, flexion and extension to bilateral shoulders, elbows, wrist, fingers, hips, knees, ankle and toes daily. R72's medical record note dated 9/9/15, by RN-D indicated R72 had ROM limitations to bilateral lower extremities, was wheelchair dependent and required total staff assistance for wheelchair mobility and was at risk for decline in ROM. The note indicated a restorative program would be set up in order to prevent any decline. R 72's care plan dated 12/19/14, indicated R72 was transferred with two staff and an E-Z lift and utilized a wheelchair for mobility. The care plan failed to include the restorative nursing program. On 11/6/15, at 1:03 p.m. RN-B confirmed R72's restorative program was not identified on R72's care plan and stated it had just got missed. R203's admission minimum data set (MDS) dated 9/4/15, identified R203 had a severe cognitive impairment and diagnoses which included non-Alzheimer dementia and hypertension. The MDS indicated R203 required extensive assist from staff for bed mobility, transfers, dressing,	F 279	re-assessed to assure they are receiving the appropriate care. Care plans are being audited to assure that cares are adequately reflected. Care plans have been updated as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to assess and treat residents with ambulation and ROM needs. Staff members have also been educated on care plan development. An all staff educational meeting was held on November 30, 2015. Random audits will be completed by the Nurse Managers and/or DON daily for 2 weeks and then weekly for one month and then monthly. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or designee	

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F 279	Continued From page 18 toileting, and ambulation. R203's physical therapy (PT) discharge note dated 9/11/15, indicated R203 was to walk to meals. R203's Rehabilitative Care sheet dated 9/16/15, indicated R203 was to walk to meals and to the bathroom as able with assist of one staff and walker. R203's care plan dated 11/4/15, directed staff to R203 with a front wheeled walker and assist of one staff. The care plan failed to include the restorative nursing program / the frequency of the ambulation. On 11/2/15, at 5:00 p.m. before the dinner meal R203 was observed to be wheeled to the dining room. On 11/4/15 at 7:00 a.m. nursing assistant (NA)-A assisted R203 with morning cares. R203 used a 4 wheeled walker (an assistive walking device) to move from the bed and transfer into her wheel chair, while NA-A and NA-B used a gait belt to assist R203. NA-A wheeled her to the dining room for breakfast. On 11/5/15, at 6:05 a.m. NA-A stated R203 very rarely attempted to self transfer any more and did not go for walks anymore. NA-A stated R203 could walk a couple of steps which involved R203 standing with her walker placed in front of her and taking several steps to the wheelchair or the recliner. NA-A stated R203 really leaned forward and needed to sit down shortly after she stood due to being unsteady. NA-A stated it had been several weeks since R203 had walked to the	F 279		

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F 279	Continued From page 19 dining room. On 11/5/15, at 11:25 a.m. RN-A unit manager verified R203's care plan did not include the restorative nursing plan / walking program. RN-A stated R203 was to be on a walking program as recommended by the PT however, the task for the nursing assistants to complete was never put into the computer theretofore the NA's were not aware of R203's ambulation program. The Care Planning policy dated 9/2013, directed staff to provide care according to the residents' individual care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		12/15/15

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F 280	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include the current passive range of motion (PROM) program for 1 of 5 residents (R23) reviewed for ROM. Findings include: R23's care plan dated 4/8/15, indicated R23 was dependent on staff for all activities of daily living. The plan directed staff to perform restorative nursing services as directed by the nurse manager. The nursing assistant Point of Care (POC) program directed activity staff members to complete PROM which included stretching to the upper and lower extremities for ten repetitions. The goal was to ensure R23 maintained the ability to sit in her wheelchair and hold her daughters hand during visits. The documentation did not direct the staff as to which joints were to receive PROM. On 11/5/15, at 6:10 a.m. NA-G was observed to provide morning cares for R23. NA-G was able to open R23's left hand to wash it. She was able to move the shoulder slightly to wash under it. The left elbow did not extend during cares. NA-G then washed the right side. The right hand was able to open, but the fingers did not extend past	F 280	Corrective Action- the care plan of R 23 has been modified to reflect the proper Passive Range of Motion program. Corrective Action as it applies to other residents- All residents with Passive Range of Motion needs have the potential to be effected by this deficient practice. An audit was conducted and any residents with Passive Range of Motion needs have been re-assessed to assure they are receiving the appropriate care. The care plans have been revised based upon resident needs. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to assess and treat residents with Passive Range of Motion needs. Staff members have been educated on accurate MDS and Care Plan coding. Care plans have been revised to reflect the resident needs. MDS□s have been reviewed. All staff educational meetings were held on November 30, 2015. Random care plan audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON are responsible for the audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or designee	

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90 degrees. The left elbow did not extended and the left shoulder was able to be moved for R23 in order for the staff to wash under the arm. NA-G stated R23 upper extremities were unable to be fully extended.

At 6:15 a.m. NA-H entered the room to assist with cares. NA-H and NA-G completed lower body cares. R23's feet remained in a pointed position (foot drop) as the staff assisted with donning socks. R23's legs were observed to remain together and slightly bent at the knees as the NAs completed perineal cares and donning pants. NA-H stated R23 had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move. NA-H stated R23 had not changed in the past year.

On 11/5/15, at 11:26 a.m. R23 was observed to receive passive range of motion from AA-A while seated in her wheelchair. AA-A was observed to gently move R23's hands, elbows and shoulders. AA-A completed repetitive movements on each joint. She was able to fully extend R23's left hand. The left elbow and shoulder did not fully extend. R23's right hand was able to be opened, but the fingers were not observed to be straightened. The elbow and shoulder were moved, but were not observed to be fully extended. At 11:37 a.m. AA-A knelt on the floor and began to do leg exercises for R23. AA-A moved R23's hip and knees while she was seated in the chair. At no time did AA-A observed to attempt to do passive ROM to R23's feet.

On 11/6/15, at 8:30 a.m. RN-C verified the care

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F 280	Continued From page 22 plan needed to be revised to direct the staff how to complete passive ROM for R23. The Care Planning policy dated 9/2013, directed the staff to revise the care plans according to resident need.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the standard of practice when administering medications for 1 of 6 residents (R61) observed for medication administration practices. Findings include: On 11/2/15, at 4:31 p.m. licensed practical nurse (LPN)-C was observed to prepare R61's medications which included Coumadin 2 milligrams (mg) tablet (anticoagulant-blood thinning medication), Pepcid 20 mg tablet (acid reducing medication), Simvastatin 40 mg tablet (cholesterol lowering medication) and Metoprolol 50 mg tablet (blood pressure/heart medication). LPN-C placed the medications in a medicaiton cup and handed the cup to trained medication assistant (TMA)-A. -At 4:33 p.m. TMA-A took the medication cup and went to R61's room which was not observable	F 281	Corrective Action- R 61 has been reviewed and the staff member has been educated on the proper correct method of medication administration. Corrective Action as it applies to other residents- all residents who receive medications have the potential to be effected by this deficient practice. A medication pass audit was conducted and staff members are being monitored during medication pass. Nurse Managers and DON are responsible to perform the audits and correct issues as noted on audit. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the proper way to pass medications. All staff educational meetings held on November 30, 2015. Random medication pass audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or	12/15/15

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	245368	A. BUILDING _____ B. WING _____	11/06/2015

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F 281	Continued From page 23 from LPN-C's medication cart and administered R61 the medications. -At 4:36 p.m. TMA-A returned to the medication cart and LPN-C asked TMA-A if she had given R61 the medications and if R61 had taken the medications. TMA-A verified R61 had taken the medications. LPN-C stated, "I don't usually do this, but R61 does not always let everyone into his room, and so it is easier to give them to someone else to give [to R61]." LPN-C stated she did not sign off on the medications until after they had been given. LPN-C verified TMA-A was a trained medication assistant and could dish and administer medications. LPN-C verified TMA-A should have dished R61's medications then administered them. On 11/5/15, at 1:51 p.m. the director of nursing (DON) verified medications should be given by the nurse who dished the medications. The DON stated being LPN-C had dished R61's medications, LPN-C should have followed TMA-A and made sure the medications were given. The DON verified the facility policy related to medication administration was not followed. The facility policy, Medication Administration-General Guidelines Policy dated 2006, indicated the person who prepared the medication dose for administration was the person who was to administer the dose.	F 281	Don will be responsible to complete the audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		12/15/15

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F 282	Continued From page 24 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services as directed by the individual care plan for 2 of 2 residents (R99, R23) in the sample who required assistance with oral cares, for 1 of 3 residents (R23) who required assistance perineal cares and for 2 of 2 residents (R122, R65) who were to receive restorative nursing rehabilitation services. Findings include: R99 did not receive oral cares as directed by the care plan. R99's care plan dated 12/17/14, directed staff to provide oral swabs for oral cares twice a daily and provide mouthwash. On 11/5/15, from 7:10 a.m. until 7:26 a.m. nursing assistant (NA)-G was observed to assist R99 with morning cares. At no time did NA-G offer R99 oral cares. -At 7:26 a.m. R99 was assisted to the dining room for breakfast. -At 8:50 a.m. after the meal, NA-H assisted R99 from the breakfast table into the restroom. At no time was NA-H observed to offer oral cares.	F 282	Corrective Action- R 23 has been reassessed for perineal care needs. R 23 and R 99 have been re-assessed for oral care needs. R 122 an R 65 have been re-assessed for their rehab service□s needs. All of these residents are now receiving the proper cares. The care plans of these residents are current. Corrective Action as it applies to other residents- all resident with perineal, oral care and rehab services needs have the potential to be effected by this deficient practice. A resident cares audit was conducted to assure that the residents with these needs are receiving the proper care. The care plans of these residents have been updated as appropriate. The care plans policy was reviewed and revised as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to provide the proper cares. All staff educational meetings were held on November 30, 2015. Random audits related to peri cares, oral cares and rehab needs (care plan implementation audit) will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON are responsible for the audits. The nursing staff will be responsible to conduct the audits with oversight by the	

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F 282	Continued From page 25 On 11/5/15, at 8:55 a.m. NA-H stated oral cares were to be completed before breakfast. She verified she had not offered or provided R99 oral cares after the meal. On 11/5/15, at 9:14 a.m. NA-G verified she had not offered or provided R99 oral cares and should have during morning cares. On 11/5/15, at 9:20 a.m. registered nurse (RN)-A verified staff should have completed R99's oral cares as directed by the care plan. R23 did not receive oral cares or perineal cares as directed by the care plan. R23's care plan dated 1/7/15, indicated R23 did not have teeth and directed staff to provide oral cares twice a day. The care plan also directed staff to provide perineal cares after each incontinent episode and to utilize protective skin creams. On 11/5/15, at 6:15 a.m. NA-G was observed to provide R23 with morning cares. R23 was observed to be totally dependent upon staff to complete the task and was unable to verbally communicate. -At 6:20 a.m. NA-H entered the room and assisted NA-G with the cares. -At 6:30 a.m. R23 was transferred from the bed to a wheelchair via a fully body mechanical lift. -At 6:35 a.m. R23 was wheeled to the breakfast table.	F 282	DON. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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F 282	Continued From page 26 -At 8:57 a.m. NA-H wheeled R23 from the dining room to her room. NA-G and NA-I assisted R23 transferred R23 to bed. -At 9:00 a.m. NA-H and NA-I were observed to check R23's incontinent brief. R23's incontinent brief was observed saturated with urine. Both NAs removed the brief and applied a new one. At no time were the NAs observed to cleanse R23's perineal area following the incontinent episode nor were the NAs observed to provide R23 oral cares. On 11/5/15, at 9:05 a.m. NA-H stated oral cares were to be completed before the meal and perineal cares were to be provided after an incontinent episode. NA-H verified she had not provided R23 oral cares or perineal cares as directed by the care plan. On 11/5/15, at 9:15 a.m. NA-G verified she had not completed oral cares during morning cares. On 11/5/15, at 9:20 a.m. RN-A stated oral cares and perineal cares were to be completed as directed by the care plan. R122 did not receive rehabilitation services six days a week as directed by the care plan/rehab. plan. R122's care plan, dated 11/6/15, directed staff to refer to R122's restorative nursing program plan documentation for specific needs / services to be provided. R122's Restorative program date	F 282		

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F 282	Continued From page 27 3/25/15, indicated R122 was to receive active range of motion (ROM) to right upper extremities due to left sided hemiplegia and weakness. R122's Restorative program dated 5/14/15, included the addition of R122 was to receive splint/brace training to left hand and gentle stretching of left wrist. Both programs were to be completed six days a week. On 11/5/15, at 7:15 a.m. R122 was observed in bed. R122 stated she was to receive rehab services six days a week and she had not been getting the services. R122 stated this week, Mon-Wed. (11/2/15-11/4/15) she had not received rehab services. However, R122 stated yesterday she had chosen to attend a Christian activity and being she had attended the activity, she could not get rehab services. R122 also stated the rehab department was to be open seven days a week and that was not happening. R122 stated some weeks, the department cut down to being open only three days and someday's they just closed the doors and there was no rehab provided because the rehab staff were pulled to work on the floor. On 11/05/15, at 2:15 p.m. rehab aid/TMA-A verified R122 had not been receiving her rehab as indicated on her restorative plan due to being pulled from the rehab department and having to work on the floor. Rehab aid/TMA-A stated when that happened, the rehab doors were closed and no rehab was provided for any of the residents. On 11/6/15, at 10:20 a.m. RN-B reviewed and verified R122's care plan and rehab directives	F 282		

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F 282	Continued From page 28	F 282		

and stated R122 was to receive the services six days per week as directed. RN-B verified R122 had not been receiving rehab services as directed due to the rehab staff being pulled from the rehab department.

R65 did not receive rehabilitation services 6 days a week as directed by the care plan.

R65's care plan dated 8/24/15, directed staff to refer to R65's restorative nursing and tasks in point click care (PCC) for specific program information. The program directed staff to provide restorative ambulation which consisted of Nu step level 4's 10 minutes and lower extremity 3 pound ankle weights-kick and march's 30 repetitions seven day per week. The program also included restorative dressing and grooming which included active ROM bike 200 turns, Red Flex bar 20 repetitions, clothes pin and cord sort 1 time and free weights 30 repetitions which was to be provided six days a week.

On 11/5/15, at 7:35 a.m. R65 stated she was not receiving rehab services. R65 stated she was to be receiving the services six days a week and the department was closed both Saturday (10/31/15) and Sunday (11/1/15) and also Monday (11/2/15) and part of Tuesday (11/3/15). R65 stated the rehab staff were pulled to work the floor so they just closed the rehab doors.

On 11/5/15, at 8:30 a.m. LPN-F stated there were days when Rehab was closed due to being short of staff and it was usually on the weekends but

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F 282	Continued From page 29 verified it also happened on some weekdays. LPN-F stated R65 was very loyal to her rehab program and she did not like to miss it. On 11/5/15, at 2:08 p.m. rehab aide/TMA-A stated R65's rehab plan directed R65 to attend six days per week but R65 would come seven days a week. TMA-A verified R65 had not received services as directed by the care plan. On 11/6/15, at 10:20 a.m. RN-B verified R65 had a rehab program which was to be provided six day per week. RN-B confirmed R65 had not received the services as directed by the care plan. The Care Planning policy dated 9/2013, directed staff to provide care according to the residents' individual care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to to ensure there was	F 309	Corrective Action- R 72 is now receiving the proper w/c positioning. R 117 is now	12/15/15

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F 309	Continued From page 30 coordination of care for 1 of 1 (R117) resident reviewed for hospice services and in addition the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R72) reviewed for wheelchair positioning. Findings include: Hospice R117 was receiving hospice services and the facility and hospice agency had not coordinated the care and services R117 was to receive. R117's medical record progress noted dated 6/10/15, indicated indicated R117 was admitted to Hospice. The record lacked individualized interventions describing how often the hospice home health aide (HHA) would visit, what day the HHA would visit or what services the HHA would provide. R117's quarterly Minimum Data Set (MDS) dated, 9/16/15, indicated R117 diagnoses included cancer, anemia, malnutrition and was terminal. The MDS indicated R117 was totally dependent of staff for all activities of daily living. R117's care plan dated 6/22/15, indicated hospice would direct care for pain/discomfort. R117's hospice care plan for the HHA updated on 9/8/15, indicated a HHA would visit one to two times per week to provide mouth care, fingernail	F 309	receiving the appropriate Hospice care and Grand Village and Hospice are working together to assure care coordination. The care plans are current. Corrective Action as it applies to other residents- all residents in need of w/c positioning and those on Hospice have the potential to be effected by this deficient practice. An audit of cares and services was conducted to assure that the residents with these needs are receiving the proper care. The care plans of these residents have been updated as appropriate. OT will evaluate the resident□s w/c positioning needs. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to provide the proper cares. All staff educational meetings were held on November 30, 2015. Random audits of cares and services, including w/c positioning will be completed by Nurse Managers and/or the DON daily for 2 weeks and then weekly for one month and then monthly. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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F 309	Continued From page 31	F 309		

care, peri-care, dressing, transferring, bathing as needed, positioning, toileting, socialization and tidy room. Facility Contact forms included the visit date, what discipline from the hospice agency visited R117, collaboration with facility staff and next planned visit.

A review of R117's Contact forms from 8/17/15, through 11/5/15, revealed the hospice HHA had visited R117 four times as follows:

-On 8/26/15, the hospice HHA noted P117 was assisted with lunch. The section for collaboration with facility staff was blank and the section for next planned visit was also blank.
-On 9/9/15, the HHA noted R117 was assisted with lunch. The section for collaboration with facility staff was blank and the section for next planned visit was also blank.
-On 10/23/15, the HHA had documented collaboration with facility staff but the section for next planned visit was blank.
-On 10/30/15, the HHA indicated R117 was sleeping and the facility nurse reported no concerns. The section for collaboration with facility staff was blank and the section for next planned visit was also blank.

On 11/5/15, at approximately 2:30 p.m. registered nurse (RN) -B was questioned about coordination of care with hospice staff when the agency visited R117. RN-B stated there was no set schedule and the facility did not know what day, when or how often the hospice HHA made visits.

On 11/6/15 at 8:30 a.m. R117 was observed seated in a wheelchair at the dining room table

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F 309	Continued From page 32 taking a few bites of her breakfast. R117 was non-verbal, eyes were closed most of the time and R117 appeared very lethargic. On 11/6/15, at 8:30 a.m. nursing assistant (NA)-E was questioned about interventions or cares the hospice HHA provided for R117 when at the facility. NA-E stated there was no set schedule of when the HHA visited and depending on when the HHA came, sometimes they would give R117 an extra bath and if they came at mealtime they might assist R117 with meals. On 11/6/15 at 8:40 a.m. RN-B stated the hospice RN came to the facility last evening, 11/5/15, and explained R117's care plan. The hospice nurse stated the HHA did not have a set schedule for visits because their hospice case load varied so they came when they could. RN-B verified the facility did not know when the hospice HHA staff were coming or what services they would be providing. RN-B confirmed R117's hospice services were not well coordinated or individualized according to R117's needs. On 11/6/15, at 9:08 a.m. R117's hospice nurse was interviewed on the telephone and stated the hospice HHA was supposed to visit R117 every Friday but the time varied depending on the HHA's prior visits of the day and the case load. The nurse indicated the HHA should have collaborated with the facility staff and documented when their next planned visit would be.	F 309		

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F 309	Continued From page 33 On 11/6/15, at 9:32 a.m. NA-E stated she worked with R117 most days and was not aware the hospice HHAs visited R117 on Fridays. NA-E also stated she was not aware of the hospice and facility contact sheet which would have had the dates listed of the next HHA visit. On 11/6/15, at 10:20 a.m. the director of nursing stated hospice agency's used to have a schedule or calendar to indicated when they would be at the facility and if that is not the process now, then something had changed. The facility Hospice Program policy revised January 2014, indicated when a resident participated in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family would be developed and would include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the patient's current status. Wheelchair positioning: R72 required positioning assistance and the facility failed to assist and identify the need for a proper fitting wheelchair. R72's annual Minimum Data Set (MDS) dated 9/7/15, indicated R72 was diagnosed with dementia, osteoarthritis, chronic kidney disease and heart disease. The MDS indicated R72 had	F 309		

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F 309	Continued From page 34 cognitive impairment, was non ambulatory, required extensive assist of two staff for transfers and extensive assist of one staff for wheelchair mobility / locomotion on and off the unit. The MDS also indicated R72 was non-ambulatory. R72's care plan dated 12/19/14, indicated R72 had cognitive impairment and difficulty communicating wants / needs and directed staff to anticipate R72's needs. The plan indicated R72 was transferred with a E-Z mechanical lift and utilized a wheelchair for mobility and directed staff to use foot pedals on the wheelchair if R72 was out of the room or off unit. R72's occupational therapy (OT) care plan dated 7/2/15, and signed by OT-A on 8/9/15, indicated R72 was referred to therapy due to multiple conditions which included dementia, abnormal posturing and a significant decline in wheelchair positioning. The plan indicated R72 required skill therapy to improve functional activities of wheelchair positioning. R72's short term goal dated 7/30/15, indicated R72 would position feet on elevating legs rests in order to maintain proper positioning and comfort. R72's long term goal dated 9/23/15, indicated R72 would maintain proper positioning of legs on elevating leg rest at all times in order to maintain proper positioning and comfort. On 11/06/15, at 10:15 a.m. R72 was observed seated in a wheelchair with feet extended past the leg rests and resting on top of the edge of the foot pedals instead of resting flat on the pedals. A the same time, OT-A who was the director of	F 309		

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F 309	Continued From page 35 physical therapy verified R72's feet were not positioned correctly on the foot pedals. OT-A stated R72's wheelchair did not fit him and would need to have a new evaluation for proper wheelchair positioning. On 11/6/15, at 10:25 a.m. licensed practical nurse (LPN)-D stated R72 had a recent decline and had not wheeled his wheelchair anymore therefore required the use of the foot pedals. LPN-D stated R72 also required total staff assistance for all positioning needs. On 11/6/15, at 10:42 a.m. OT-A stated R72 was evaluated for wheelchair positioning on 7/2/15, and at that time foot rests were added to the wheelchair. OT-A stated the facility should have followed up on the effectives of R72's foot pedals one month after they were initiated, but it had slipped through the cracks. On 11/6/15, at 10:55 a.m. R72 was observed seated in a wheelchair in the television room. One of R72's feet was resting on top of the foot pedal and the other foot had slid off the side of the foot pedal and was resting on the floor. On 11/6/15, at 12:50 p.m. the physical therapist stated an evaluation of R72's lower extremities was just completed and it was determined R72 had motion available in the lower extremities but was resistive to range of motion. The PT stated R72's feet were appropriately placed on the foot rest but R72 did not leave them there.	F 309		

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F 309	Continued From page 36 On 11/6/15, at 1:03 p.m. registered nurse (RN)-B stated R72's knees had gotten stiffer and was not sure if the arthritis had worsened or if R72 was declining in range of motion. RN-B confirmed R72's foot pedals were not appropriate for him and stated R72 would be evaluated by OT for wheelchair positioning. RN-B stated R72 would also be assessed by nursing to determine if R72's pain medication for stiffness of the knees needed to be increased or changed. A policy and procedure for wheelchair positioning was requested but was not provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 1 of 1 resident (R203) in the sample reviewed for restorative nursing ambulation services and for 1 of 1 resident (R65) in the sample reviewed for rehab nursing services. Findings include:	F 311	Corrective Action- R 203 is being ambulated according to the ambulation plan. The care plan was reviewed and it is current. R 65 is receiving Range of Motion. The care plan of R 65 has been updated. Corrective Action as is applies to other residents- all residents with ambulation and ROM needs have the potential to be effected by this deficient practice. An audit of ROM and ambulation plans was conducted and care plans updated to reflect the current ambulation/ROM needs	12/15/15

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F 311	Continued From page 37 R203's admission Minimum Data Set (MDS) dated 9/4/15, indicated R203 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance from staff for bed mobility, transfers, dressing, toileting and ambulation. R203's Activities of Daily Living Care Area Assessment dated 9/11/15, indicated R203 had received physical therapy (PT) and occupational therapy (OT) to increase strength and independence. R203's PT discharge therapy note dated 9/11/15, indicated R203 was to walk to meals. R203's Rehabilitative Care sheet dated 9/16/15, indicated R203 was to walk to meals and to the bathroom as able with assist of one staff and walker. R203's care plan, dated 11/4/15, indicated R203 was to ambulate with a front wheeled walker and assist of one staff. However, the plan did not address R203's restorative program. On 11/2/15, at 5:00 p.m. staff were observed to wheel R203 into the dining room. On 11/4/15 at 7:00 a.m. nursing assistant (NA)-A was observed to assist R203 with morning cares. NA-A applied a transfer belt around R203's waste and assisted R203 as she utilized a four wheeled walker (an assistive walking device) to transfer self from the bed and into the wheelchair. NA-A wheeled R203 to the dining room for breakfast.	F 311	of the residents. The policy on ambulation and ROM was reviewed and revised as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to provide the proper ambulation/ROM program. All staff educational meetings were held on November 30, 2015. Random ambulation and ROM audits, including observation and review will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and the DON are responsible for the audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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F 311	Continued From page 38	F 311		

On 11/5/15, at 6:05 a.m. NA-A stated R203 very rarely attempted to self transfer any more and no longer went for walks. NA-A stated R203 could walk a couple of steps such as standing with her walker in front of her and transferring taking several steps to the wheelchair or the recliner. NA-A stated R203 really leaned forward when standing and needed to sit down shortly after she stood up due to being unsteady. NA-A stated it had been several weeks since R203 had walked to the dining room.

On 11/5/15, at 11:25 a.m. RN-A verified R203 was to be on a walking program as recommended by the PT however, the task directive for the NAs to follow was never put into the computer. RN-A stated she had seen R203 walk with one staff and walker from the day room to the dining room on 10/29/15. At this time, NA-A was asked to walk R203. R203 was observed to slowly walk from the day room into the dining room. Following this observation, RN-a stated she was going to in-put R203's PT recommendation for the ambulation program into the computer so that the NAs would have to document R203's ambulation each day.

R65 did not receive range of motion/rehab services as directed on the care plan/nursing restorative program.

R65's admission MDS dated 8/31/15, indicated R65 was diagnosed with diabetes, congestive heart failure and degenerative joint disease. The

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F 311	Continued From page 39	F 311		

MDS also indicated R65 had intact cognition and was independent in ambulation, bed mobility and required limited assist with dressing. R65's Activities of Daily Living Care Area Assessment dated 9/11/15, indicated R65 was currently participating in rehab nursing services for active range of motion (AROM) and walking. The MDS indicated during the MDS reference period R65 had received seven days of rehab nursing services.

R65's Physical Therapy Plan of care dated 1/16/15, indicated R65 had been referred due to weakness status post coronary angiography.

R65's care plan dated 8/24/15, directed staff to refer to R65's restorative nursing and tasks in point click care (PCC) for specific program information. The Restorative plan dated 8/24/25, indicated staff were to provide R65 ambulation, Nu step level 4's 10 minutes and lower extremity three pound ankle weights/kick and march 30 repetitions seven days per week. In addition staff were directed to provide a restorative dressing and grooming program which was dated 12/15/14, and included active ROM on bike 200 turns, Red Flex bar 20 reps, clothes pin and cord sort once and free weights for 30 reps. The program was to be completed 6 days a week.

R65's Functional/Safety Assessment dated 9/1/15, indicated R65 was currently receiving rehab nursing every day to maintain her ability in full ROM.

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F 311	Continued From page 40 On 11/5/15, at 7:35 a.m. R65 stated she was not receiving rehab services. R65 stated she was to be receiving the services six days a week and the department was closed both Saturday (10/31/15) and Sunday (11/1/15) and also Monday (11/2/15) and part of Tuesday (11/3/15). R65 stated the rehab staff were pulled to work the floor so they just closed the rehab doors. On 11/5/15, at 8:30 a.m. LPN-F stated there were days when Rehab was closed due to being short of staff and it was usually on the weekends but verified it also happened on some weekdays. LPN-F stated R65 was very loyal to her rehab program and she did not like to miss it. On 11/5/15, at 2:08 p.m. rehab aide/TMA-A verified R65's rehab plan directed R65 to attend six days per week but stated R65 would come seven days a week. TMA-A verified R65 had not received services as directed by the care plan as the rehab person had been pulled from the rehab department quite a bit. The rehab staff schedule was reviewed with rehab aide/TMA-A and the following was revealed: -10/3/15, no rehab staff, department was closed. -10/4/15, no rehab staff, department was closed. -10/5/15, rehab staff pulled at 8:30 a.m. to work the floor for the day. -10/10/15, no rehab staff available, department closed -10/13/15, staff was pulled from the department -10/17/15, rehab staff was pulled form the department and she quit.	F 311		

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F 311	Continued From page 41 -10/18/15, no rehab staff available, department closed -10/27/15, rehab staff were pulled from the department all day -10/29/15, pulled all day -10/30/15, pulled until 10:15 a.m. -10/31/15, pulled all day -11/1/15, pulled all day -11/2/15, pulled all day -11/3/14, staff was pulled from the department from 8:00 a.m.-10:30 a.m. On 11/6/15, at 10:20 a.m. RN-B verified R65 had was to receive rehab / restorative services as directed stated it was more for R65's maintenance and strengthening program which was to be provided six days per week. RN-B confirmed R65's care plan was not being followed. The undated, Restorative Care Policy indicated the objective was directed toward assisting each resident to achieve and maintain their highest level of self-care through positioning, range of motion and ambulation. The policy also indicated the residents' would be assessed at time of admission by PT/OT whereby PT/OT would determine goals and level of restorative care upon discharge from PT/OT therapy services.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		12/15/15

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F 312	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 2 of 2 residents (R23, R99) in the sample who were dependent on staff for oral hygiene. In addition the facility failed to complete perineal cares for 1 of 1 resident (R23) who was incontinent of urine and dependent upon staff for perineal cares. Findings include: R99 did not receive oral cares as directed by the care plan. R99's significant change Minimum Data Set (MDS) dated 9/4/15, indicated R99 was diagnosed with dementia, anxiety and seizure disorder. The MDS also indicated R99 had cognitive impairment, had no teeth and required extensive to total assistance with all activities of daily living. R99's Dental Care Area Assessment (CAA) dated 9/15/15, indicated R99 did not have teeth but was a risk for issues with chewing food, bleeding and infection. The CAA indicated staff provided R99 oral cares daily and as needed by using half strength mouthwash and oral swabs daily. R99's care plan dated 12/17/14, directed staff to utilize oral swabs for oral cares twice a daily and	F 312	Corrective Action- Oral cares have been provided to R23 and R 99. The care plans of these residents have been reviewed and updated as appropriate. Perineal cares have been provided to R 23. The care plan was reviewed and updated. Corrective Action as it applies to other residents- all residents with oral care and perineal care needs have the potential to be effected by this deficient practice. An audit was completed and care plans were updated to reflect the oral care needs and/or perineal care needs of these residents. The care plan policy was reviewed and revised as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to provide the appropriate oral cares. All staff educational meetings were held on November 30, 2015. Random oral care and peri care audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON are responsible for the audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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F 312	Continued From page 43 provide mouthwash. On 11/5/15, from 7:10 a.m. until 7:26 a.m. nursing assistant (NA)-G was observed to assist R99 with morning cares. At no time did NA-G provide or offer R99 oral cares. -At 7:26 a.m. R99 was assisted to the dining room for breakfast. -At 8:50 a.m. NA-H assisted R99 from the breakfast table to the restroom. At no time was NA-H observed to offer or provide R99 oral cares. On 11/5/15, at 8:55 a.m. NA-H stated oral cares were to be completed before breakfast. She verified she had not offered oral cares after the meal. On 11/5/15, at 9:14 a.m. NA-G verified she had not offered or provided R99 oral cares and stated she should have provided oral cares during morning cares. On 11/5/15, at 9:20 a.m. registered nurse (RN)-A verified staff should have completed oral cares as directed by R99's care plan. R23 was not provided oral cares or perineal cares as directed by the care plan. R23's quarterly MDS dated 9/29/15, indicated R23 had dementia, severe cognitive impairment, was incontinent of bladder and required required total assistance with all activities of daily living	F 312		

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F 312	Continued From page 44 including oral cares. R23's care plan dated 1/7/15, indicated R23 had no teeth and directed staff to provide oral cares twice a day. The plan also directed staff to provide perineal cares after each incontinent episode and to utilize protective skin creams. On 11/5/15, at 6:15 a.m. NA-G was observed to provide R23 with morning cares. R23 was observed to be totally dependent upon staff to complete the task and was unable to verbally communicate. -At 6:20 a.m. NA-H entered the room and assisted NA-G with the cares. -At 6:30 a.m. R23 was transferred from the bed to a wheelchair via a fully body mechanical lift. -At 6:35 a.m. R23 was wheeled to the breakfast table. -At 8:57 a.m. NA-H wheeled R23 from the dining room to her room. NA-G and NA-I assisted R23 transferred R23 to bed. -At 9:00 a.m. NA-H and NA-I were observed to check R23's incontinent brief. R23's incontinent brief was observed saturated with urine. Both NAs removed the brief and applied a new one. At no time during the observations were the NAs observed to cleanse R23's perineal area following the incontinent episode nor were the NAs observed to provide R23 oral cares. On 11/5/15, at 9:05 a.m. NA-H stated oral cares were to be completed before the meal and perineal cares were to be provided after an incontinent episode. NA-H verified she had not provided R23 oral cares or perineal cares as	F 312		

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F 312	Continued From page 45 directed by the care plan. On 11/5/15, at 9:15 a.m. NA-G verified she had not provided R23 oral cares during morning cares. On 11/5/15, at 9:20 a.m. RN-A stated oral cares were to have been completed during morning cares as directed by the care plan. She also stated perineal cares were to be completed following each incontinent episode. The Mouth Care policy dated 10/2010, directed staff to provide oral cares to ensure the residents lips and oral tissues were moist, to cleanse and freshen the resident's mouth and to prevent infections of the mouth. The Perineal Care polity dated 10/2010, directed the staff to provide perineal cares following each incontinent episode.	F 312		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced	F 318		12/15/15

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F 318	Continued From page 46 by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) ability for 3 of 3 residents (R23, R72, R122) in the sample who had limitations in range of motion. Findings include: R23 did not receive range of motion services to minimize limitations in range of motion. R23's quarterly Minimum Data Set (MDS) dated 9/29/15, indicated R23 had dementia, aphasia (loss of ability to understand or express speech), severe cognitive impairment, had limited ROM on one side of the upper body and required total staff assistance with all activities of daily living. R23's annual MDS dated 6/29/15, also identified R23 as having limited ROM on one side of her upper body. R23's Nursing Assessment dated 9/28/15, indicated R23 had limitations in ROM on one side of her upper extremity and had no limitations in her lower extremities. R23's care plan dated 4/8/15, indicated R23 was dependent upon staff for all activities of daily living and directed staff to perform restorative nursing program services as directed by the nurse manager.	F 318	Corrective Action- R 23, R 72, and R122 have been reassessed for their ROM needs. Their care plans have been updated to reflect their current needs. Corrective Action as it applies to other residents- all residents with ROM needs have the potential to be effected by this deficient practice. An audit of resident ROM needs was completed and care plans have been updated as appropriate. PT/OT is involved in resident ROM needs as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to provide the appropriate ROM to residents. All staff educational meetings were held on November 30, 2015. Random ROM/Care Plan audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON are responsible to complete these audits. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 47 R23's nursing assistant Point of Care (POC) program directed the activity staff to provide R23 passive ROM exercises which included stretching to the upper and lower extremities for ten repetitions each. The goal was to ensure R23 maintained the ability to sit in her wheelchair and hold her daughters hand during visits. Review of the Restorative Passive ROM documentation for October 2015, indicated R23 had revived ROM for 20 minutes six days a week. The documentation did not identify which joints or limbs received the ROM. Review R23's clinical record lacked progress notes related to R23's progress or regression of her restorative program. On 11/4/15, at 7:08 a.m. nursing assistant (NA)-F and NA-H were observed to transfer R23 from bed into a wheelchair via a full body mechanical lift. R23's hands were observed to be in a closed (loose) fisted position. R23 was not observed to move her arms or her legs independently throughout the observation. -At 7:15 a.m. NA-H was observed to apply bilateral sleeve protectors to R23's arms. R23 did not assist in the application. NA-H applied a sweater in which R23's shoulders and elbows were not observed to extend to assist with the application of the sweater. R23's hands remained in a closed position during the application of the sleeves and sweater.	F 318		

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	245368	A. BUILDING _____ B. WING _____	11/06/2015

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F 318	Continued From page 48 On 11/4/15, at 7:53 a.m. NA-F was observed to feed R23 the breakfast meal. R23 was not observed to move her upper extremities and was totally dependent upon the staff for meal. -At 9:15 a.m. NA-G and NA-F were observed to transfer R23 from the chair to bed via the mechanical lift. Once in bed, NA-G and NA-F provided R23 with incontinence cares. R23's legs were observed slight bent at the knees and clamped together and her feet were observed to be in a pointed downward position (foot drop). On 11/4/15, at 1:10 p.m. activity aide (AA)-A stated R23 received passive ROM six days a week during activities. AA-A stated the activity staff completed arm and leg repetitions for about 20 minutes each day. AA-A also stated R23's arms and legs had been "tight" but were much better and R23 seemed stronger after receiving the assistance with ROM. On 11/5/15, at 6:10 a.m. NA-G was observed to provide morning cares for R23. NA-G was able to open R23's left hand and wash it and move R23's left shoulder slightly to wash under it. The left elbow did not extend during cares. NA-G was also able to open R23's right hand to wash, however, R23's fingers did not extend past 90 degrees. R23's right elbow did not extend and the shoulder was able to be moved to allow for cleansing. NA-G stated R23's upper extremities were unable to be fully extended. -At 6:15 a.m. NA-H entered the room to assist with cares. NA-H and NA-G both completed R23's lower body cares. R23's feet remained in a foot drop as staff assisted with donning socks.	F 318		

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F 318	Continued From page 49 R23's legs were observed to remain together and slightly bent at the knees as the NAs completed perineal cares and applied R23's pants. NA-H stated R23 had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move. NA-H stated R23 had not changed in the past year. On 11/5/15, at 9:20 a.m. registered nurse (RN)-D stated she completed the MDS but did not complete bedside ROM assessments on dependent residents'. RN-D stated all MDS coding was transcribed from the Nursing Assessment which was completed by the RN-A -At 9:25 a.m. RN-D was observed to complete ROM for R23 while R23 was in bed. RN-D stated R23 displayed bilateral upper and lower limitations in range of motion in the shoulders, elbows, hands and hips, knees and feet. -At 9:40 a.m. RN-D verified the MDS was not coded correctly as it did not identify R23's limitations in ROM in both upper and lower extremities. At the same time, RN-A verified she had completed R23's 9/28/15, Nursing Assessment, and stated at that time, R23 only had limitations on one side of her body. RN-A stated she completed the ROM assessment at the bedside for all dependent residents. On 11/5/15, at 11:26 a.m. AA-A was observed to perform passive ROM exercises for R23 while R23 was seated in the wheelchair. AA-A was observed to gently move R23's hands, elbows and shoulders. AA-A completed repetitive movements on each joint. She was able to fully	F 318		

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extend R23's left hand. The left elbow and shoulder did not fully extend. R23's right hand was able to be opened, but the fingers were not observed to be straightened. The elbow and shoulder were moved, but were not observed to be fully extended.
-At 11:37 a.m. AA-A knelt on the floor and began to do leg exercises for R23. AA-A moved R23's hip and knees while she was seated in the chair. At no time was AA-A observed to attempt to do passive ROM to R23's feet.
-At 11:43 a.m. AA-A completed the cares.

On 11/5/15, at 11:45 a.m. AA-A stated a former RN had trained her to complete ROM exercises. She stated she had been assisting R23 with ROM for greater than a year. AA-A verified R23 had limitations in ROM ability but they had not changed in the past year. She verified at no time did she complete ROM to R23's feet.

On 11/5/15, at 11:50 a.m. RN-A stated she had observed AA-A perform ROM exercises but had not completed any type of documentation related to AA-A's ROM program / services. RN-A stated AA-A would report any concerns of ROM to her.

On 11/5/15, at 2:20 p.m. RN-A stated the identified concerns related to R23's limited ROM abilities were all new since 9/28/15. She stated RN-C was in charge of the restorative program and any concerns would be identified in RN-C's documentation.

On 11/5/15, at 2:30 p.m. RN-C stated she was the restorative program liaison. She stated staff

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members met on a monthly basis to review the restorative program. RN-C stated AA-A had not attended the restorative meetings nor provided feedback related to the residents' receiving ROM from the activity staff. RN-C stated any documentation related to the restorative programing completed by AA-A would be up to RN-A to complete. RN-A verified she had not completed restorative reviews on AA-A's residents including R23. The surveyor requested for RN-C to locate any therapy documentation related to R23's restorative program as the current medical record did not contain therapy evaluations.

On 11/6/15, at 8:30 a.m. RN-C verified RN-D completed the MDS assessment but did not go onto the nursing units to perform ROM assessments. She stated RN-D was to complete the MDS according to the Nursing Assessment documentation. RN-C stated the Nursing Assessment completed on 9/28/15, would have been the assessment used for the completion of the quarterly MDS dated 9/29/15. RN-C stated RN-D would have only went on to the nursing units and personally assessed a resident only when needed to check areas of concern if the documentation contraindicated itself. She stated RN-D was not expected to complete ROM for R23 prior to the completion of an MDS.

On 11/6/15, at 8:42 a.m. RN-D reported she had located R23's past therapy evaluations. The Physical Therapy Evaluation dated 3/27/13, indicated R23 had bilateral limitations in ROM in the lower extremities including hips, knees and feet. On 6/28/14 a passive ROM program was initiated at which time R23 was identified with bilateral imitations in her shoulders, arms and

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hands. RN-D also provided email communication dated 10/16/14, between herself and RN-A in which RN-A indicated R23 was no longer able to move her feet.

On 11/6/15, at 8:45 a.m. RN-C stated R23 should be receiving ROM to her feet in order to prevent further foot drop.
-At 8:47 a.m. RN-D stated she had interviewed several long term staff members who all indicated R23's ROM had not changed in the past year.
- At 9:00 a.m. RN-C stated the facility restorative program policy directed the unit mangers to monitor the residents' ROM program to ensure they were receiving the necessary services to maintain/prevent further decline.

R72 did not receive range of motion services to minimize limitations in range of motion.

R72's annual MDS dated 9/17/15, indicated R18 was diagnosed with dementia, osteoarthritis and had severe cognitive impairment, bilateral lower extremity limitations in ROM and did not walk.

R72's care plan dated 12/19/14, indicated R72 utilized a wheelchair and was transferred with two staff and an E-Z mechanical lift. The care plan did not identify a nursing restorative program.

R72's medical record included a restorative program note dated 9/9/15, written by RN-B and had late entry next to the date. The note described R72 as having limitations to bilateral lower extremities in both knees. The note indicate R72 was able to flex and extend, invert and avert

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ankles, hips and all other joints of the lower extremities. The note indicated R72 was at risk for decline in ROM, was wheelchair dependent and required staff assist to propel to all destinations. The further indicated a restorative program would be set up in order to prevent any decline and R72 would be re-evaluated next quarter.

R72's medical record indicated on 9/5/15, RN-B initiated a new restorative program for R72 for the NAs to complete. The program consisted of passive range of motion six times per week and directed staff to provide abduction, adduction, flexion and extension to bilateral shoulders, elbows, wrist, fingers, hips, knees, ankles and toes daily.

On 11/06/15, at 10:15 a.m. R72 was observed seated in a wheelchair with both legs extended straight out and resting on top of the foot pedals, not on the foot pedals.

On 11/6/15, at 10:25 a.m. licensed practical nurse (LPN)-D stated R72 had a recent decline in which R72 no long wheeled own wheelchair, hardly fed himself like he used to an required total staff assist for all positioning needs.

R72's monthly rehab schedule was reviewed and indicated PROM was only completed two times in September on 9/6/15, and 9/20/15. There was no record PROM was competed in October or November.

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F 318	Continued From page 54 On 11/6/15, at 1:03 p.m. RN-B stated a task form was completed in R72's medical record to direct nursing staff to complete and sign off when completed. RN-B confirmed R72's PROM was only signed off as being completed only twice. RN-B verified R72's record had no other documentation which indicated ROM had been provided to R72. R122 did not receive range of motion services to minimize limitations in range of motion (ROM) as directed by the care plan. R122's quarterly MDS dated 8/20/15, indicated R122 was diagnosed with hemiplegia (paralysis on one side of the body) and anxiety. The MDS also indicated R122 had intact cognition, limited ROM on one side of the upper / lower body and required extensive assistance with all activities of daily living. R122's Activities of Daily Living CAA dated 2/23/15, indicated R122 had a fall while living in assisted living and sustained a head injury and had a stroke many years ago which resulted in the hemiparesis on the left side. The CAA indicated R122 was receiving physical therapy (PT) and occupational therapy (OT) for rehabilitation and at that time R122 was taking 3 steps in physical therapy. R122's care plan, dated 11/6/15, directed staff to refer to nursing restorative documentation for program specifics. R122's restorative program dated 3/25/15, indicated R122 was to receive active ROM services to the upper extremities.	F 318		

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F 318	Continued From page 55 R122's restorative program dated 5/14/15, indicated R122 was to receive splint / brace training to the left hand and gentle stretching of left wrist. Both programs were to be provided six days per week. On 11/5/15, at 7:15 a.m. R122 was observed in bed. R122 stated she was to receive rehab services six days a week and she had not been getting the services. R122 stated this week Mon-Wed. (11/2/15-11/4/15) she had not received rehab. However, R122 stated yesterday she had chosen to attend a Christian activity and being she had attended the activity, she did not get rehab services. R122 also stated the rehab department was to be open seven days a week and that was not happening. R122 stated some weeks, the department cut down to being open only three days a week and someday's they just closed the doors and there was no rehab provided because the rehab staff were pulled to work on the floor. On 11/05/15, at 2:15 p.m. the rehab/ trained medication aide (TMA)-verified R122 had not received rehab services as directed on her restorative plan due to being pulled from the rehab department and having to work on the floor. Rehab aid/TMA-A stated when that happened, the rehab doors were closed and no rehab was provided for any of the residents. On 11/6/15, at 10:20 a.m. RN-B reviewed and verified R122's care plan and rehab directives and stated R122 was to receive the services six days per week as directed. RN-B verified R122	F 318		

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F 318	Continued From page 56 had not received rehab services as directed due to the rehab staff being pulled from the rehab department. The undated, Restorative Care Policy indicated the objective was directed toward assisting each resident to achieve and maintain their highest level of self-care through positioning, range of motion and ambulation. The policy also indicated the residents' would be assessed at time of admission by PT/OT whereby PT/OT would determine goals and level of restorative care upon discharge from PT/OT therapy services. The Care Planning policy dated 9/2013, directed staff to provide care according to the residents' individual care plan.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision to ensure the safety for 1 of 1 resident (R148) who displayed wandering behaviors which resulted in falls, resident to	F 323	Corrective Action- R 148 has been assessed for safety on the unit and interventions have been put into place to keep her safe. Her care plan has been updated. Resident is being closely	12/15/15

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F 323	Continued From page 57 resident physical altercations or inappropriate touching. Findings include: R148's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R148 was diagnosed with dementia, anxiety disorder, depression and a seizure disorder. The MDS also indicated R148 had severe cognitive impairment and displayed physical aggression towards others 1-3 days and wandering behaviors 4-6 days of the MDS assessment period. The MDS also indicated R148 required extensive assistance with actives of daily living and required supervision to limited assistance of one staff while ambulating. R148's The Activities of Daily Living Care Area Assessment (CAA) dated 12/29/14, indicated R148 was able to ambulate independently without any type of assistive device and was at risk for falls. R148's Cognition CAA dated 12/29/15, indicated R148 was diagnosed with dementia and was at risk for further cognitive decline due to disease progression. R148 had difficulty communicating wants/needs and the staff were to anticipate her needs. R148's Falls CAA dated 12/29/15, indicated R148 was at risk for falls due to wandering. Staff were to be aware of R148's whereabouts and her	F 323	monitored by unit staff and they are separating her from other residents as necessary. Corrective Action as it applies to other residents- All residents on this unit have the potential to be affected by the behaviors of resident 148. Staff members have been educated on the need to intervene and separate residents. Staff members have also been educate on the need to attempt distraction techniques when R148 is wandering. The residents care plan was reviewed and revised to reflect the need to monitor resident and separate her from other residents when necessary. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to intervene and separate residents to prevent behaviors. They have also been educated to use distraction technique when R148 is wandering. All staff educational meetings were held on November 30, 2015. Random observational audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers/DON are responsible for the audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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F 323	Continued From page 58 interactions with others and to intervene if potential problems were identified. R148's care plan dated 12/26/14, indicated R148 was at risk for falls, wandered throughout the nursing unit and was unable to remove herself from harm. The care plan directed staff to intervene and separate resident from harm when safety concerns were identified, to ensure R148 was not alone with R145 and to keep the environment safe. On all days of the survey conducted on 11/2/15, from 1:00 p.m. to 8:00 p.m., on 11/3/15, from 8:00 a.m. to 4:30 p.m., on 11/4/15, from 7:00 a.m. to 3:30 p.m., on 11/5/15, from 6:00 a.m. to 2:30 p.m. and on 11/6/15, from 8:00 a.m. to 1:00 p.m. R148 was observed to pace non stop on the memory care unit. R148 was observed to wander in and out of other resident rooms, pick up items that may or may not have belonged to her and was observed to bump into furniture and other residents in her path that also resided on the unit. On 11/3/15, R148 was continually observed from 3:48 to 4:20 p.m. During this time, R148 was observed to ambulate throughout the unit carrying one shoe which was much too large for her foot. She carried the shoe into room 420 and out again. R148 walked the length of the nursing unit and walked into a resident room at the other end of the unit. At not time were the staff members on the unit observed to redirect her. -At 3:50 p.m. R108 began wandering with R148. The two residents did not speak to each other as they walked together.	F 323		

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F 323	Continued From page 59 -At 3:51 p.m. R148 was observed to bump into a chair in the dining area. She moved the chair slightly as she continued to walk the unit with R108. Shortly thereafter, both residents entered room 420 and exited it at 3:52 p.m. -At 4:04 p.m. R108 left R148 and the two residents continued to walk in separate directions. On 11/4/15, from 7:04 a.m. to 9:30 a.m. R148 was observed to have one on one observations from a nursing assistant (NA). Nursing assistant (NA)-I, NA-H and NA-F took turns walking with R148 and assisting with her meal. R148 was observed to be very sleepy and at times would walk with her eyes closed. The NA's were observed to guide R148 around obstacles in her environment to ensure her safety. -At 9:27 a.m. NA-H stated R148 required one on one assistance because she had sustained a fall during a grand mal seizure at 6:00 a.m. and was extra tired and weak following the seizure activity. R148's Progress Notes were reviewed and revealed the following: - On 2/27/15, at 10:20 p.m. R148 was found on the floor with her pants around her ankles. R108 (female resident with dementia) attempted to assist R148 by pulling her hair. R108 hit R145 on the head. R148 was assisted by staff to stand and R108 continued to try and grab R148 and pull her in another directions. The residents were separated by the staff. The Incident Report dated 2/27/15, directed the staff to watch, intervene and separate residents.	F 323		

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- On 3/6/15, at 6:13 p.m. R148 was up to another resident in a common area. R22 (a female resident with dementia)slapped R148 several times on the hand. The Incident Report dated 3/6/15, directed the staff to redirect the residents.

-On 3/17/15, at 3:45 p.m. R148 was found in the Rivers Community seated next to R145 (a male resident with dementia). R145 had his hand down R148's pants. The staff members separated the residents and directed the staff to continue to monitor R148's whereabouts and intervene as necessary.

- On 3/29/15, at 8:12 p.m. R148 was found in R145's room holding hands with R145. R148 was standing in front of R145 and he had his pants down with his penis out. Staff members intervened and removed R148 from R145's room. The Incident Report dated 3/29/15, directed the staff to monitor R148's whereabouts.

- On 4/3/15, at 2:30 p.m. R148 was found in R145's room (male resident with dementia). R148 was found seated partially on the arm of a recliner and partially on R145's lap. R145 had his hand resting on her upper thigh. The Incident Report directed the staff to place a fall mat inside R145's door and hang a stop sign.

- On 4/16/15, at 2:30 p.m. R148 wandered by an unidentified resident and the unidentified resident hit her in the arm. The Incident Report dated 4/16/15, directed the staff to intervene with other residents.

- On 4/21/15, at 5:30 p.m. R148 walked by R55 (male resident) and R55 reached out and

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grabbed R148's hand. He was directed by the staff to let go of R148 but refused. As staff approached R55, he yanked on R148's hand causing her to stumble and almost fall onto him. The Incident Report dated 4/21/15, directed the staff to monitor for bruising and keep the residents away from each other.

- On 4/21/15, at 11:07 p.m. R108 (female resident with dementia) entered room 418 carrying a foot rest from a wheelchair. R148 was observed seated on the bed. Staff intervened and R108 grabbed R148's breast and would not let go. Staff redirected the residents. The Incident report dated 4/21/15, directed the staff to watch the residents closely and observe for bruising.

- On 4/21/15, at 11:26 p.m. R148 hit R108 over the head with a cloth pad. The Incident Report dated 4/21/15, directed the staff to monitor for mood changes.

- On 4/22/15, at 10:10 p.m. R148, wandered into another room and the door closed. When this happened, R148 fell onto her buttocks. The Incident Report dated 4/22/15, directed the staff to observe resident safety and direct R148 to bed if tired.

- On 7/3/15, at 10:22 a.m. R148 was hit by an unidentified resident with a call light. R148 sustained a bruise to the right hand. The Incident Report dated 7/3/15, indicated the staff had changed the call light to one made of a softer material.

- On 7/5/15, At 1:08 p.m. R148 wandered into R99's (a female resident with dementia) room. R99 became agitated and upon staff intervention,

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R99 hit R148 on the right shoulder. The Incident Report dated 7/5/15, indicated the staff separated the residents. They offered to shut R99's door, but she opened it again.

- On 7/8/15, at 10:10 p.m. R63 grabbed R148 in the left upper arm. Before staff could intervene R63 punched R148 in the left arm. The staff members separated the residents. The Incident Report dated 7/8/15, directed the staff to try to keep the other residents away from R148.

- On 7/12/15, at 11:30 a.m. R148 was walking around the room and entered room 415-2. The unidentified resident in the room became upset with R148 and hit her in the lower back. The incident Report dated 7/12/15, directed the staff to attempt to keep the residents separated.

- On 7/14/15, at 10:20 a.m. R148 walked by another resident when the unidentified resident grabbed R148's arm and would not let go. R148 then grabbed the unidentified resident and she too would not let go of the other resident. The Incident report dated 7/14/15, directed the staff to attempt to separate the residents and to intervene when needed.

- On 7/19/15, at 1:27 p.m. R148 was hit in the right should by an unidentified resident. The Progress note directed the staff to monitor for bruising. The Incident Report dated 7/19/15, directed the staff to separate and intervene as appropriate.

- On 8/3/15, at 1:51 p.m. R148 entered room 419 and attempted to get an unidentified resident out of the room. R148 grabbed the unidentified resident's shirt sleeve and would not let go. The

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F 323	Continued From page 63 staff members separated the residents. - On 8/16/15, at 8:30 p.m. R93 (a female resident with dementia) grabbed R148's arm strongly and hit her in the left eye/face area. The staff moved R148 away from R93. - On 8/30/15, at 3:45 p.m. R148 received a bump on her forehead/hairline from walking into a glass door and hitting her head on the door. The Incident report dated 8/30/15, directed the staff to be more aware of R148's proximity to doors opening and closing. - On 9/4/15, at 7:50 a.m. the staff members heard a crashing noise in R148's room. The staff found R148 seated on the floor. The progress Note did not indicate any type of injury. The Incident Report directed the staff to watch for residents alertness while ambulating. - On 9/11/25, at 11:06 p.m. R148 was found standing over an unidentified resident while the resident was in bed. The unidentified resident grabbed R148's wrists and started to scream. The residents were separated. The Incident Report dated 9/11/15, directed the staff to separate residents to prevent conflicts. - On 9/24/15, at 2:42 p.m. R148 was hit/slapped on the upper left chest area by R187. No injury was noted. The Incident Report dated 9/24/15, directed the staff to separate the residents. - On 9/24/15, at 9:48 p.m. R148 was found in the serenity room on the floor with a record player and side table next to her. No apparent injury. the Incident report dated 9/24/15, directed the staff to encourage R148 to go to bed when tired.	F 323		

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F 323	Continued From page 64 - On 10/17/15, at 11:39 a.m. R148 was found in room 416 on the floor holding a weighted blanket from a mechanical lift. No injury was noted. The Incident Repot dated 10/17/15, directed the staff to ensure the mechanical lift was locked and in place when not in use. - On 10/25/15, at 8:33 p.m. R148 was observed walking around the unit, in and out of other resident rooms, bumping into furniture and other objects. At this time she walked by an unidentified resident and tripped over the resident's feet, causing her to fall to the floor. No injuries noted. The Incident Report dated 10/25/15, directed the staff to remove R148 from unsafe situations if able. - On 10/29/15, at 2:10 p.m. R148 was observed on R187's (female resident with dementia) room. R187 attempted to hit R148 but staff were able to intervene. The Incident Report directed the staff to monitor and separate the residents as able. - On 11/3/15, at 10:30 a.m. the staff heard a noise from room 420. R148 may have bumped her head on the door while walking out of the room. R148 sustained a 0.5 centimeter (cm) by 2.0 cm red area on her forehead. No incident report was noted for this occurrence. On 11/4/15, at 12:00 p.m. family member (FM)-A stated R148 had increased wandering in the past year. She stated she was aware R148 entered other resident rooms and often picked up items that did not belong to her. She stated the facility staff kept an eye on R148 as best as possible.	F 323		

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On 11/4/15, at 12:48 p.m. licensed practical nurse (LPN)-I stated R148 wandered around the Lakes Neighborhood and at times would have altercations with other residents. She stated when that happened, the residents were separated. LPN-I stated R148 would also occasionally fall or sit on the floor by herself. She stated R148 did not have any specific fall precautions when ambulating, but utilized a fall mat by her bed and a parameter mattress on the bed. LPN-I stated if she noticed residents hitting at each other, the residents would be separated. She stated she was aware of R148 being involved with resident to resident altercations, but had not observed any of the alleged altercations.

On 11/4/15, at 1:02 p.m. activity aide (AA)-A stated R148 continuously wandered and paced on the unit. AA-A stated she not feel R148 disrupted other residents but confirmed R148 occasionally tripped over other residents. AA-A stated when she noticed R148 wandering she would try to engage R148 in a one to one activity.

On 11/4/15, at 1:22 p.m. NA-H stated R148 wandered daily. She stated R148 did not seem to be afraid of any of the other residents nor did the other residents seem to be afraid of R148. She stated occasionally the residents would slap out at each other and when this happened, she separated the residents.

On 11/4/15, at 1:40 p.m. licensed social worker (LSW)-A stated she had not been made aware of any concerns related to resident to resident concerns on the Lakes Neighborhood. She

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confirmed at the time of survey, the facility had two residents with dementia (R148 and R108) who wandered daily in and out of other residents rooms. She also stated R187 had displayed aggressive behaviors towards staff and other residents. She verified the Lakes Neighborhood was busy and had an increased risk for resident to resident altercations. She verified the facility had not completed any type of formal interventions to increase supervision on the Lakes Neighborhood.

On 11/5/15, at 12:06 p.m. registered nurse (RN)-A stated the altercations involving R148 occurred with other residents with dementia therefore, the residents were just to be observed and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed as R148 did not attempt to open the doors which decreased the behaviors with some of the male residents. She stated the facility had not put any other interventions in place to increase the supervision on the Lakes Neighborhood.

On 11/5/16, at 12:14 p.m. LSW-A stated the facility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations. She stated the only new intervention was to close the doors between the two dementia units.

On 11/5/15, at 12:17 p.m. the director of nurses (DON) stated the facility had provided the staff members education regarding approaching residents with dementia. She stated the activity

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F 323	Continued From page 67 staff and the kitchen staff members had also received training so they could assist with the residents as needed. On 11/5/15, at 12:26 p.m. the DON stated when there were concerns on the Lakes unit, she or other staff members, when available, had gone to the Lakes unit to assist. The DON confirmed there had been no increase in supervision or change in staffing structure on the Lakes unit following the resident to resident altercations as noted above. A policy related to staff supervision of patients with dementia was requested and none was provided.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident with	F 325	Corrective Action- R 203 has been assessed related to supplements. The	12/15/15

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F 325	Continued From page 68 anticipated nutritional decline received nutritional supplementation according to the assessed need and preference in order to minimize weight loss for 1 of 3 (R203) residents reviewed for nutrition. Findings include: R203's admission Minimum Data Set (MDS) dated 9/4/15, indicated R203 had dementia and a severe cognitive impairment. The MDS also indicated R203 weighed 149 pounds and required supervision from staff while eating. R203's medical record revealed the following: -on 8/29/15, R203 weighed 149 pounds (lbs.) -on 9/12/15, weighed 145 lbs. -on 10/25/15, weighed 140 lbs. -on 11/2/15, 137 lbs. R203's Dietician Progress note dated 10/27/15, indicated R203 had a weight loss and was started on 4-6 ounce house or house juice supplementation three times a day between meals. R203's physician's order dated 10/27/15, indicated R203 was started on a house supplement or juice supplement 4-6 ounces three times a day between meals. R203's Nurse Progress noted dated 11/3/15, and completed by registered nurse (RN)-A indicated R203's weight was almost 10 pounds less than	F 325	care plan has been updated to reflect the order. The TAR has been correctly updated to reflect the orders. Corrective Action as it applies to other residents- all residents on nutritional supplements have the potential to be effected by this deficient practice. Residents have been reviewed and interviewed for preference. Their care plans have been updated to reflect needs and preferences. The TARs of these residents reflect their needs. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on nutritional supplements and preferences. Random MAR/TAR nutritional supplement audits will be completed daily for 2 weeks and then weekly for one month and then monthly. All staff educational meetings were held on November 30, 2015. The Nurse Managers and/or DON are responsible for the audits. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored by: DON or Designee	

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her baseline weight. The dietitian had been alerted on that date and R203 was started on a house supplement three times a day on 10/27/15, with the hope R203's weight returned to baseline soon. However, the supplement was never started.

On 11/4/15, from 7:30 a.m. until 8:30 a.m. R203 was observed in the dining room eating breakfast. R203 consumed several bites of toast, a cup of hot chocolate and three ounces of apple juice. R203 had been very busy talking to herself and did not appear interested in eating.

On 11/5/15, at 6:10 a.m. licensed practical nurse (LPN)-B stated she was not aware R203 was to receive a nutritional supplement. LPN-A reviewed R203's Treatment Administration Record (TAR) which would have identified the need to provide R203 a supplement, stated the TAR had not indicated R203 was to receive and no directive to provide R203 a nutritional supplement. LPN-A stated she had not provided R203 a supplement when she worked the day shift.

On 11/5/15, at 11:15 a.m. RN-A verified the dietitian had written an order for R203's supplement on 10/27/15, however stated it was never started because the order was in-putted into the computer wrong.

A policy, Medical Nutrition Therapy (MNT) Recommendations, undated, indicated MNT recommendations from the registered dietitian/dietetic technician would be implemented

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F 325	Continued From page 70 or reason for non-implementation would be documented. Any recommendations, which need nursing's attention or a physician's order, would be forwarded in writing to the nursing staff.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive sleep assessment and sleep	F 329	Corrective Action- R 203 has been assessed and indications for use of Trazadone have been established. The	12/15/15

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F 329	Continued From page 71 monitoring was completed and failed to identify non- pharmacological interventions for sleep prior to the administration of a hypnotic (used for sleep) for 1 of 5 residents (R203) reviewed for unnecessary medications. Findings Include: R203's admission Minimum Data Set MDS dated 9/4/15, indicated R203 had dementia with severe cognitive impairment and required extensive staff assist for mobility, dressing and toileting. Section D0200 of the MDS did not indicate R203 had any trouble falling or staying asleep or sleeping too much. R203's care plan dated 9/17/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R203's Nursing Assistant (NA) care plan did not include any non-pharmacological interventions to promote sleep. R203's current physician's orders dated 10/12/15, directed staff to administer Trazodone HCL tablet 50 mg by mouth at bed time for insomnia. On 11/5/15, at 5:55 a.m. R203 was observed in bed, asleep. -At 6:00 a.m. NA-A and NA-B were observed to transfer R203 from bed into the wheelchair, wheel	F 329	pharmacist has reviewed the medication. The care plan has been updated to reflect the indication for use. Non-pharmacological interventions have been added to the care plan and MAR. Corrective Action as it applies to other residents- all residents receiving psychotropic medications have the potential to be effected by this deficient practice. The resident□s medications have been reviewed and indications for use are in place. The care plans of these residents have been updated to reflect their needs. Non-pharmacological interventions have been added to the MAR and Care Plans as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on psychotropic medication indications for use. The use of non-pharmacological interventions was addressed at the all staff educational meetings which were held on November 30, 2015. Random MAR audits related to psychotropic medications use and non-pharmacological interventions will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON will be responsible. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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F 329	Continued From page 72 R203 to the dining room and provide R203 with a cup of coffee. -At 7:40 a.m. R203 was observed eating independently. On 11/5/15, at 11:43 a.m. registered nurse (RN) verified R203 was on Trazadone due to not sleeping. RN-A stated she did not complete a sleep study assessment prior the initiation of or after the medication was administered. RN-A also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R203's medical record. In addition, RN-A verified R203's care plan lacked any indication R203 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs / symptoms of adverse reactions to monitor for. A policy on conducting sleep studies was requested however, no policy was received.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/15/15

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F 371	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate procedures were implemented in order to maintain adequate holding temperatures of pasteurized hard boiled eggs when served from the resident salad cart. The facility also failed to implement appropriate food temperature procedures related to cleaning the thermometer probe in between food items temped. These practices had the potential to affect all 111 residents in the facility who received food from the kitchen and / or salad cart. Findings include: Norway dining room: On 11/2/15, at 5:00 p.m. nursing assistant (NA)-K was observed in the Norway dining room with a salad cart. The cart was observed to contain a large bowl of lettuce and several smaller bowls which contained boiled pasteurized eggs, cheese, carrots, pickled beets, cucumbers and sunflower seeds. The cart did not have a system to ensure the salad toppings were kept cool prior to service. -At 5:03 p.m. NA-K began to wheel the salad cart from table to table asking the residents in the dining room if they wanted a salad and assisted them to build a salad of their choice. At this time, the surveyor approached NA-K and requested the temperature of the boiled eggs be checked. The eggs were found to be 48 degrees Fahrenheit (F). NA-K stated the salad cart had been prepared by	F 371	Corrective Action- The Lakes kitchenette has been cleaned. Food temperatures are now being monitored for safe handling. Corrective Action as it applies to other residents- All residents have the potential to be effected by the condition of the kitchenettes. All kitchenettes have been cleaned and food temperatures are now being monitored. The kitchenette cleaning policy and the food temperature policies have been reviewed and revised as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to have clean kitchenettes and to monitor food temperatures to assure safe food handling. All staff educational meetings were held on November 30, 2015. Random kitchen and food temperature audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON will be responsible. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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	245368	A. BUILDING _____ B. WING _____	11/06/2015

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F 371	Continued From page 74 the dietary staff and arrived on the Norway neighborhood between 4:00 - 4:15. NA-K verified the salad cart contained boiled eggs which should be kept cool when served and stated the facility did not have a system in place to ensure the items remained cool. NA-K removed the boiled eggs from the salad cart. Wolf/Moose Lodge Dining Room: On 11/2/15, at 5:20 p.m. the nursing staff in the Moose / Wolf dining room were observed wheeling a salad cart into the kitchen. The nursing staff stated they had just finished offering all the residents in the dining room a salad. The cart was observed to contain a large bowl of lettuce and several smaller bowls that contained boiled pasteurized eggs, cheese, carrots, pickled beets, cucumbers and sunflower seeds. At this time, cook (C)-A checked the temperature of the eggs which measured 48 degrees F. The dietary manager stated staff had taken the food items out of the refrigerator earlier and wheeled them on to the Lodge/Wolf dining room. On 11/4/15, at 11:59 a.m. NA-C was observed wheeling a salad cart with a large bowel of salad and several other salad items which were set in a larger bowel that was filled with ice. NA-C stated the ice was something new and the kitchen staff had set up the cart with salad items being placed on ice. The undated Storage of Good policy directed staff	F 371		

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F 371	Continued From page 75 to ensure cold food was maintained at 32-40 degrees and an internal thermometer was to be kept in all refrigerators and freezers. Woods Dining room: On 11/04/2015, at 11:28 a.m. DA-A was observed to pick up the food service tray from the main kitchen for the Woods dining room lunch meal. DA-A was observed to place the food containers into the steam table. DA-A used a yellow food thermometer probe to obtain food temperatures. DA-A inserted the probe into the chicken nuggets without cleaning the probe first. DA-A inserted the same probe into the chicken breast (186 degrees) Fahrenheit (F) at which time DA-A wiped the probe off with a paper towel. DA-A proceeded to check the temperature of the rice (195 F) and the sweet and sour sauce (195 F). DA-A rinsed the thermometer probe under running water at the sink and wiped it off with a paper towel. DA-A proceeded to temp the broccoli (178 F), followed with the mashed potatoes (182 F). DA-A wiped the thermometer probe off with a paper towel. DA-A temped the hamburger patties and wiped the probe off with a paper towel then proceeded to temp the gravy (187 F). DA-A rinsed the thermometer off under running water and wiped off the probe with a paper towel. DA-A checked the temp of the lettuce (38 F) and cheese (40 F). DA-A was not observed to clean the thermometer probe between foods. On 11/4/15, at 12:57 p.m. DA-A stated, " I am suppose to use the wipes to clean the thermometer probe after each food, and I did not	F 371		

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F 371	Continued From page 76 do that." On 11/4/15, at 2:05 p.m. the DM stated food sanitizing wipes should have been utilized to cleanse the thermometer probe between each food item. However, the DM stated she was aware some of the neighborhoods were out the proper probe cleansing wipes so staff should have used alcohol wipes to clean the probes in between each food item until the probe cleansing wipes came in. The undated, Cleaning Instructions: Thermometers policy indicated thermometers would be cleaned and sanitized before and after each use.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consultant pharmacist failed to ensure sleep patterns were identified and monitored in	F 428	Corrective Action- R 203 has been assessed and indications for use of Trazadone have been established. The	12/15/15

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F 428	Continued From page 77 order to determine sleep medication effectiveness and failed to ensure non pharmacological interventions had been identified and implemented prior to the use of hypnotic (for sleep) medication for 1 of 1 resident (R203) who received daily medication for sleep. Findings Include: R203's admission Minimum Data Set MDS dated 9/4/15, indicated R203 had dementia with severe cognitive impairment and required extensive staff assist for mobility, dressing and toileting. Section D0200 of the MDS did not indicate R203 had any trouble falling or staying asleep or sleeping too much. R203's care plan dated 9/17/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R203's Nursing Assistant (NA) care plan did not include any non-pharmacological interventions to promote sleep. R203's current physician's orders dated 10/12/15, directed staff to administer Trazodone HCL tablet 50 mg by mouth at bed time for insomnia. The consulting pharmacist November 2015, report did not address R203's usage of Trazodone or sleep.	F 428	pharmacist has reviewed the medication. The care plan has been updated to reflect the indication for use. Non-pharmacological interventions have been added to the care plan and MAR. Corrective Action as it applies to other residents- all residents receiving psychotropic medications have the potential to be effected by this deficient practice. The resident□s medications have been reviewed and indications for use are in place. The care plans of these residents have been updated to reflect their needs. Non-pharmacological interventions have been added to the MAR and Care Plans as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on psychotropic medication indications for use. The use of non-pharmacological interventions was addressed at the all staff educational meetings which were held on November 30, 2015. Random MAR audits related to psychotropic medications use and non-pharmacological interventions will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON will be responsible. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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F 428	Continued From page 78 On 11/5/15, at 11:43 a.m. registered nurse (RN) verified R203 received Trazadone due to not sleeping. RN-A stated she did not complete a sleep study assessment prior the initiation of or after the medication was administered. RN-A also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R203's medical record. In addition, RN-A verified R203's care plan lacked any indication R203 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs / symptoms of adverse reactions to monitor for. RN-A confirmed the consulting pharmacist had not identified or addressed R203's Trazadone use for sleep. The policy, Consultant Pharmacist Reports/Medication Review (Monthly Report), undated, indicated the consultant pharmacist reviewed the medication regimen of each resident monthly. The consultant pharmacist's evaluation included evaluating indications for use of a medication, what monitoring was being completed for the medication and appropriateness of the medication.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		12/15/15

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F 431	Continued From page 79 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled and dated when opened for 1 of 6 residents (R122) whose medications were observed for medication storage. In addition, the facility failed to ensure expired stock Aplisol (serum protein derivative used to test for tuberculosis infection) was discarded after being opened greater than 30 days. This had the	F 431	Corrective Action- The medications are now dated and labeled appropriately. Corrective Action as it applies to other residents- all residents receiving medications have the potential to be effected by this deficient practice. The medications of all residents have been audited to assure date and label are correct. The nursing staff members have	

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F 431	Continued From page 80 potential to affect all new admission on 1 of 4 units (Cedar) and newly hired staff. Findings include: On 11/4/15, at 8:54 a.m. an opened multi-dose vial of Aplisol was observed in the Cedar wing medication storage room refrigerator with and "open date" of 8/21/15, handwritten on the label. Review of the JHP Pharmaceuticals, LLC (manufacturer of Aplisol) included the following guidelines for storage: "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." Licensed practical nurse (LPN)-E was present during the observation and confirmed the Aplisol serum had been open greater than 30 days and should have been discarded to ensure it was not used. -At 9:04 a.m. R122's Alphagan eye drops were stored in the medication cart was observed opened, used and undated. An unlabeled bottle of lumigan eyedrops was also observed. LPN-E stated the medication belonged to R122, and confirmed the bottle lacked a pharmacy label. LPN-E reported the medication came from the eye doctor, therefore, did not have a label indicating who the medication belonged to or directions for administration. LPN-E confirmed all eyedrop medications should be dated when opened and all medications should have a pharmacy label attached. -On 11/5/15, at 6:36 a.m. the same expired Aplisol vial remained in the Cedar wing medication refrigerator. Licensed Practical Nurse	F 431	been responsible for the audit and the DON is overseeing the audits. The medication storage and administration policies have been reviewed and revised as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to appropriately date and label medications for all residents. All staff educational meeting held on November 30, 2015. Random medication pass and review of medication label audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON will be responsible. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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F 431	Continued From page 81 (LPN)-F stated it should have been destroyed and gave the expired Aplisol to Registered Nurse (RN)-B for destruction. On 11/5/15, at 6:41 a.m. RN-B confirmed all medications should include a pharmacy label, and stated the facility should have verified the order and obtained a pharmacy label for the lumigan eye drops. RN-B stated all eyedrop medication should be dated when opened, and the Aplisol should have been disposed of when it expired, 30 days after opening the vial. On 11/5/15, at 2:29 p.m. the director of nursing (DON) indicated staff were supposed to date medication bottles when opened, including eye drops. The DON stated all medications should have a pharmacy label attached unless it was stock medication and confirmed the Aplisol should have been disposed of. A policy regarding medication storage was requested but not provided.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		12/15/15

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F 441	Continued From page 82 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain infection control standards related to the use of personal protective gloves and appropriate disinfecting of community use glucometers in 8 of 8 neighborhoods who utilized community glucometers. In addition, the facility failed to ensure proper hand hygiene and glove use during the administration of eye medication during 1 of 3	F 441	Corrective Action- All residents now have individual blood glucose monitors. Staff members have been educated on the need to wear gloves and properly wash their hands when administering eye drops to resident 122. Corrective Action as it applies to other residents- All residents on blood glucose monitoring have the potential to be	

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F 441	Continued From page 83 eye medication administration observations (R122). Findings include: Glucometer: Norway neighborhood: On 11/2/15, at 4:45 p.m. licensed practical nurse (LPN)-G was observed to approach R65 while caring a glucometer (blood glucose machine) in the Norway dining room. LPN-G did not apply gloves as she proceeded to check R65's blood sugar. Following the blood sugar check, LPN-G placed the glucometer into a caring basket and returned the glucometer to the top of the medication cart. LPN-G left the medication cart and answered a call light on the nursing unit. At no time was LPN-G observed to apply gloves while completing the glucose monitoring, sanitize the glucometer or wash her hands after completing the procedure. On 11/2/15, at 5:10 p.m. LPN-G stated the glucometer was utilized for three residents who resided on the Norway neighborhood and was to be cleaned at the end of each shift. She verified she did not wear gloves while checking R65's blood sugar as R65 did not like gloves when cares were provided. She verified she did not clean the machine and did not wash her hands after the procedure.	F 441	effected by this deficient practice. Individual blood glucose monitors have been obtained for all residents who require monitoring. The policy on blood glucose monitoring was reviewed and revised as appropriate. Staff members have been educated on the proper method of hand washing and glove use related to eye drop administration. Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to appropriately clean and blood glucose monitors and to use gloves and wash their hands appropriately when administering eye drops. All staff educational meetings were held on November 30, 2015. Random blood glucose monitoring audits and eye drop administration audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and the DON are responsible for these audits. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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F 441	Continued From page 84 On 11/2/15, at 5:23 p.m. LPN-M stated the glucometers were to be cleansed with a germicidal "Sani" wipe after each use. On 11/3/15, at 9:44 a.m. LPN-H stated the glucometer on the Norway unit was utilized for R65, R13 and R185. LPN-H stated the glucometer was to be cleaned after each use. In addition, LPN-H stated she routinely utilized gloves while completing glucose monitoring for R65. She stated at no time had R65 had any type of issues with the staff utilizing gloves during procedures. On 11/5/15, at 9:48 a.m. registered nurse (RN)-A stated the staff were to wear gloves and cleanse the glucometers after each use. Moose / Wolf Lodge neighborhood: On 11/2/15, at 4:45 p.m. LPN-L was observed to complete R41's blood glucose test. LPN-L did not apply gloves as she proceeded to check R41's blood sugar. LPN-L then wiped the glucometer with an alcohol wipe, placed the glucometer into a caring basket and returned the glucometer to the top of the medication cart. At 5:00 p.m. LPN-L completed a blood sugar check on R218. LPN-L did not apply gloves as she proceeded to check R218's blood sugar. LPN-L then wiped the glucometer machine with an alcohol wipe, placed the glucometer into a caring basket and placed it on top of the	F 441		

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F 441	Continued From page 85	F 441		

medication cart. At that time LPN-L stated the glucometer machine was used for all the residents on the Moose/Wolf Lodge and was to be cleaned between residents with an alcohol wipe.

On 11/6/15, at 8:20 a.m. RN-B stated the staff should be utilizing gloves while completing glucometers and the machines were to be cleaned after each use according to the facility policy.

On 11/6/15, at 10:30 a.m. the DON gave the surveyor a paper that stated, "Effective Immediately" each resident would be given their own glucometer. The meter was to stay in a labeled bag for each resident, all meters would be calibrated prior to use and nightly. For residents who had not yet been supplied a personal meter, staff would need to disinfect the community meter between all residents with a sani-wipe.

Aspen and Birch neighborhood:

On 11/5/15, at 7:51 a.m. LPN-D was observed to remove a TrueTRACK glucometer from the medication cart. LPN-D obtained a glucometer test strip, inserted in the glucometer and obtained R38 blood sugar and place the glucometer on top of the medication cart. LPN-D was not observed to clean the glucometer before or after use.

At 9:13 a.m. R61 stopped at LPN-D's medication cart and requested to have his blood sugar tested. LPN-D picked up the glucometer from the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 86	F 441		

top of the medication cart and inserted a test strip into the glucometer, obtained R61's blood glucose and returned the glucometer to the top of the medication cart. LPN-D was not observed to clean the glucometer prior to use or following use.

At 9:20 a.m. LPN-D verified the glucometers were to be cleaned with a Sani wipe after each use and stated she had not cleaned the glucometer as she should have.

On 11/5/15, at 11:24 a.m. RN-B verified the glucometer utilized by staff to obtain glucose monitoring on the Aspen and Birch units was a community glucometer and it was facility policy to clean the machine after each resident use. RN-B stated it was here expectation for staff to be following our facility policy.

On 11/6/15, at 8:17 a.m. RN-E stated the Spruce neighborhood utilized just one community TRUEtrack glucometer for checking blood sugars for residents..

At 9:16 a.m. LPN-K stated the Wolf neighborhood had just one community TRUEtrack glucometer used for checking resident blood sugars on this unit.

At 10:15 a.m. LPN-G stated Norway neighborhood had just one community TRUEtrack glucometer to used on the unit.

At 10:30 a.m. LPN-A stated the Rivers neighborhood had just one community TRUEtrack glucometer to use for checking blood sugars.

At 10:40 a.m. trained medication assistant

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	245368	A. BUILDING _____ B. WING _____	11/06/2015

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(TMA)-B on the Waters unit stated her supervisor completed the blood sugar checks, however verified the Waters neighborhood had just one community TRUEtrack glucometer.

The TRUEtrack glucometer manufactures owner's booklet, dated 2014 indicated for patients important health and safety information, WARNING! The TRUEtrack Blood Glucose Monitoring System was for one person use only. DO NOT share your Meter or your Lancing Device with anyone, including family members. ALL parts of your Blood Glucose Monitoring System could carry blood-borne diseases after use, even after cleaning and disinfection.

The Blood Sampling - Capillary (Finger Stick) policy dated 2014, directed staff to always ensure the blood glucose monitoring meters intended for reuse were cleaned and disinfected between resident uses. Single-resident use fingerstick devises should never be used by more than one resident.

On 11/6/15, at 11:52 a.m. The DON reviewed the TRUEtrack manufacturers owner's booklet and stated "I had no idea the glucometers were to be used for one person only. We had talked about that last week, and we were planning on going to individual lancet pens for the residents. I never thought to look at the owner's booklet for the glucometers we are currently using." The DON verified the TRUEtrack glucometers intended for single use was being used for multiple residents on the different units in the facility and even if they were cleaned between use, they could be a concern for the transmission of blood-borne diseases. The DON further stated she would get them removed from use right away. The DON

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F 441	Continued From page 88 verified staff had not followed policy for using glucometers. Eye drops: On 11/2/15, at 4:52 p.m. LPN-G was observed to stop R122 from entering the dining room. LPN-G removed R122's glasses and proceeded to place eye drops in both eyes. At no time was LPN-G observed to don gloves or wash her hands after installing the eye drops. On 11/2/15, at 5:10 p.m. LPN-G stated she had administered artificial tears to R122. She verified she should have worn gloves while administering eye drop medications and should have washed her hands after administering the medication. The Instillation of Eye Drops policy dated 1/2014, directed the staff to utilize gloves while administering eye medication. On 11/6/15, at 8:20 a.m. RN-B stated staff were to utilize gloves and wash their hands after eye medication administration.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		12/15/15

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F 465	Continued From page 89 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure wheelchair armrests, resident mechanical lifts and a lap tray were maintained in a clean and sanitary condition for 1 of 2 residents (R23) who had torn, uncleanable arm rests, for 2 of 2 residents (R23, R55) in Lakes neighborhood who required the use of a mechanical lift and for 1 of 1 resident (R25) who utilized a lap tray. In addition, the facility failed to provide a clean and sanitary environment in resident rooms for 7 of 7 resident rooms (213, 215, 310, 418, 423, 426,413) which were observed to have uncleanable surfaces attached to equipment and room furnishings. Lastly, the facility failed to ensure the kitchen and kitchen food storage areas were maintained in a clean and sanitary manner. Findings include: R23's wheelchair armrests were torn and uncleanable and the mechanical lift had non cleanable foam padding attached to it. R23's quarterly Minimum Data Set (MDS) dated 9/29/15, indicated R23 had cognitive impairment, was unable to ambulate and utilized a wheelchair for all destinations. R23's care plan dated 1/7/15, indicated R23 required the use of a wheelchair for mobility to all destinations. On 11/3/15, at 9:00 a.m. R23's wheelchair arm	F 465	Corrective Action- The arms rests of R 23 have been removed and replaced. The mechanical lifts of R 23 and 55 have been cleaned and repaired as appropriate. The lap tray of R 25 has been cleaned/replaced as appropriate. Foam has been removed from all resident equipment. The resident rooms 213, 215, 310, 413, 418, 423 and 426 have been cleaned amd equipment and room furnishings has been removed/replaced as appropriate. The kitchen and kitchen storage areas have been cleaned. Corrective Action as it applies to other residents: All residents have the potential to be effected by this deficient practice. Resident rooms and the kitchen areas have been audited and cleaned as appropriate. The Nurse Managers and DON are responsible for the audits. The cleaning schedule policy has been reviewed and revised as appropriate. Date of Completion: December 15, 2015 Recurrence will be prevented by: Recurrence will be prevented by: Staff members have been educated on the need to maintain/clean resident rooms and resident equipment. All staff educational meetings were held on November 30, 2015. The staff members have also been educated on the need to maintain clean kitchens and kitchen storage areas. Random cleaning audits will be completed daily for 2 weeks and then weekly for one month and them monthly. The Nurse Managers and the	

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F 465	Continued From page 90 rests were observed torn on both sides with visible foam padding exposed. On 11/4/15, at 7:10 a.m. nursing assistant (NA)-F and NA-H were observed to transfer R23 into the wheelchair via a full body EZ mechanical lift. The hydraulic portion of the lift moved the arm of the lift which held the sling / resident during the transfer. The lower portion of the hydraulic bar had a porous black foam piece wrapped around it and secured with black adhesive tape. The tape was peeling away from the foam. The center of the sling strap bar was also observed to have foam padding added to prevent the resident from hitting their head on the bar. NA-H stated the lift was utilized for R23 an R55. R23's wheelchair armrests were observed torn approximately 4-6 inches on both sides of the arm rest with the foam padding exposed. The arm rests and the mechanical lift were uncleanable. On 11/5/15, at 6:30 a.m. NA-H stated R23's arm rests had been torn for a long time. NA-H stated R23's family had applied tape to them in the past to make them smoother, but the tape had been removed. Review of the EZ Lift manufactures manual dated 9/2008, did not include directions or suggestions related to the addition of foam padding to the machines. On 11/5/15, at 10:55 a.m. maintenance staff (MS)-A stated he did not know when the foam padding was added to the mechanical lift. He	F 465	DON are responsible for these audits. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored by: DON or Designee	

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F 465	Continued From page 91 verified the foam padding and adhesive tape did not create a cleanable surface and was not a recommended interventions from the manufacturer. MS-A stated he would remove the padding. In addition, MS-A verified R23's arm rests were in need of repair and could easily be replaced. He stated nursing staff should have sent a work request to the maintenance director so the repair could have been completed. MS-A stated he would replace the arm rests. R25's wheelchair lap tray was not maintained in a clean and sanitary manner. R25's quarterly MDS dated 0/11/15, indicated R25 was cognitively impaired, required extensive assist with positioning, transfers and eating and a restraint to prevent R25 from rising from the chair was in place. R25's care plan dated 9/14/15, indicated R25 was to have wheelchair tray on at all times while in wheelchair and staff were directed to anticipate his needs. On 11/4/15, at 7:52 a.m. R25 was observed seated in the wheelchair, in the Woods dining with NA-K assisting him with the breakfast meal. The lap tray is observed in use. The tray was observed to have a three inch black porous foam piece taped on with two inch clear tape, along the 20 inch edge of the tray next to R25's abdomen. -At 8:54 a.m. NA-K assisted R25 to his room. NA-K verified food debris was on the tray and also on the black foam. NA-K wiped the tray off. NA-K stated the edge of the tray was sharp so	F 465		

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F 465	Continued From page 92 the foam was applied for cushion so when R25 leaned forward the edge of the tray did press against his stomach. NA-K also stated she did not now how often the foam was changed or if it was cleaned any other way than wiping it off. NA-K also stated she did not know how long it had been on and she just wiped it off when it was dirty. On 11/06/2015, at 1:53 p.m. R25 was observed in his wheelchair, asleep. R25's lap tray has food debris on the tray and on the black foam and adhesive tape. At this time, RN-B verified tray was dirty and the foam was an uncleanable surface. RN-B stated R25 needed the lap tray and staff were coming up with a plan to change the tray out and replace it with one that was safe and cleanable. On 11/6/15, at 2:10 p.m. the director of nursing (DON) verified R25's tray was needed, however, the tray with the black porous foam adhered was not a cleanable and sanitary surface. The DON stated staff were working towards removing the foam that was attached to the equipment and replace it with an acceptable option. The DON stated the facility did not have a policy related to the use of the foam padding or for cleaning it. ENVIRONMENT: On 11/6/15, from 10:45 am until 11:27 a.m. a tour of the facility was completed with the director of maintenance (DOM) and the DOM verified the following concerns: -Room 426's upper bilateral bed rails had three inch black porous foam attached to the rails and	F 465		

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F 465	Continued From page 93 taped on with two inch black tape which was raveling and had dried debris on it. The bathroom was observed to have a half inch by 14 inch long by 10 inch wide black porous foam tape was taped to the pipe on the back of the toilet, behind the toilet seat. -Room 423's upper bilateral side rails had three inch black porous foam attached and taped with two inch black tape which was raveling. The bathroom toilet was observed to have half inch by 14 inch long by 10 inch wide sheet of black porous foam taped to the pipe on the back of the toilet, behind the toilet seat. -Room 213's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape which was raveling and had dried debris on it. -Room 413's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape. -Room 215's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape which was raveling and hanging down. The tape has dried debris on it. -Room 310's bathroom door frame had two inch black tape and two inch duct tape covering an 18 inch section over the door latch, frame section. The grab bar attached to wall next to the toilet had 24 inch by three inch black porous foam attached and secured with black tape. The tape was raveling and had debris on it. The DOM verified the maintenance staff applied the foam to all of the identified areas and the	F 465		

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F 465	Continued From page 94 facility did not have a cleaning policy for the foam. The DOM stated he did not think anyone removed and cleaned the backsides or under the foam. The DOM stated the facility did not have a schedule for changing the foam. The DOM stated the facility had never thought of the safety part of infection risks or the cleaning process. The DOM verified the foam was not cleanable and stated staff had already started to remove the foam. KITCHEN: On 11/4/15, at 12:48 p.m. a tour of the kitchen was completed with the dietary manager (DM) and the following was observed: -The outer eight inch perimeter of the entire kitchen floor area was observed to have food debris and a black/gray debris build up on it. The food/black/gray debris was also observed behind the stove, under the food preparation counters and alongside and behind the food steam machine. In addition, the dry food storage area was observed to have food particles and black gray debris build up around the outer eight inch perimeter of the floor. The debris was also observed under the wire food storage shelving. The DM verified the floors were not clean and sanitary and stated staff were assigned cleaning and deep cleaning duties. The DM stated the floors were not clean and staff were not cleaning the entire flooring as directed to do so. The facility policy, "Cleaning Schedule" dated 03/05, indicated regular cleaning was scheduled	F 465		

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F 465	Continued From page 95 daily, weekly and monthly to ensure that all of the food service area was washed and sanitized. The policy indicated daily tasks included cleaning the floors, sweep and mop including the dry storage area and under all counters, fridges, cabinets and carts.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 01 Main Building (1900, 1972, 1992 and 2000 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Grand Village 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

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

Electronically Signed | 11/25/2015

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us or 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 Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in	K 000		

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K 000	Continued From page 2 between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 3 NOT MET as evidenced by:	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify several required exit doors leading to the exterior that lead to the public way in accordance with NFPA 101 (00) sections 7.10.1.7 and 7.10.7.2. These deficient practices could negatively affect residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 3:00 PM to 6:00 PM on 11/04/2015, observations revealed that the exit signs that are located Spruce, Lakes, and Rivers are not internally lit and use a type of photoluminescence lettering. These same exit signs were not visible in low lighting or dark conditions. The other exit signs located within the facility are internally illuminated.	K 022	All exit signs will be replaced to meet all requirements Completion date: 12/16/15 Responsible person: EVS Director	12/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE** **GRAND RAPIDS, MN 55744**

(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 022	Continued From page 4 This deficient practice was verified by the Maintenance Supervisor.	K 022		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by:. Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 3:00 PM to 6:00 PM on 11/04/2015, during the review of all available maintenance documentation and interview with the Maintenance Supervisor it was revealed that the facility deficient conditions: 1. the Evening shift is missing a fire drill in the 4th	K 050	Fire drills will be staggered in times in order to meet requirements. Completion date 12/16/2015 Responsible person: EVS Director	12/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE** **GRAND RAPIDS, MN 55744**

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K 050	Continued From page 5 quarter, and 2. there were 3 fire drills held in the 10 AM hour and 4 in the 10 PM hour. This deficient practice was verified by the Maintenance Supervisor.	K 050		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the	K 056	Sprinkler heads will be replaced by certified contractor. Completion date: 12/16/15 Responsible person: EVS Director	12/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE** **GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 6 facility. Findings include: On facility tour between 3:00 PM to 6:00 PM on 11/04/2015, observations have revealed that the Woods dinning room area was equipped with quick response sprinkler heads and it is open to the corridor that is equipped with standard response sprinkler heads. This situation has combined two different type of sprinkler heads with in the same compartment. This deficient practice was verified by the Maintenance Supervisor.	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 02 Sub-Acute 2004 Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Grand Village 02 Sub-Acute 2004 Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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 Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/25/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us or 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 Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

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K 000	Continued From page 2 between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**11/04/2015**

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K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 3:00 PM to 6:00 PM on 11/04/2015, during the review of all available maintenance documentation and interview with the Maintenance Supervisor it was revealed that the facility deficient conditions: 1. the Evening shift is missing a fire drill in the 4th quarter, and 2. there were 3 fire drills held in the 10 AM hour and 4 in the 10 PM hour.	K 050	Fire drills will be staggered in times in order to meet requirements. Completion date: 12/16/2015 Responsible person: EVS Director	12/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**11/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 050	Continued From page 4 This deficient practice was verified by the Maintenance Supervisor.	K 050		

Minnesota Department of Health

Electronically submitted
November 20, 2015

Ms. Susan Johnson, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5368026

Dear Ms. Johnson:

The above facility was surveyed on November 2, 2015 through November 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 ro email: lyla.burkman@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/2/15, 11/3/15, 11/4/15, 11/5/15, and 11/6/15, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan to include a restorative nursing range of motion (ROM) program for 1 of 1 resident (R72) reviewed for ROM and for 1 of 1 resident (R203) in the sample who required assistance with ambulation, Findings include: R72's annual Minimum Data Set (MDS) dated 9/17/15, indicated R72 was diagnosed with dementia, osteoarthritis and had severe cognitive impairment. The MDS indicated R72 did not walk and had limitations in ROM to both lower extremities. R72's medical record note dated 9/5/15, by	2 560	Corrected	11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	11/06/2015

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2 560	Continued From page 2 registered nurse (RN)-B indicated a new restorative program for the nursing assistants to complete was initiated. The restorative program included passive range of motion six times per week, provide abduction, adduction, flexion and extension to bilateral shoulders, elbows, wrist, fingers, hips, knees, ankle and toes daily. R72's medical record note dated 9/9/15, by RN-D indicated R72 had ROM limitations to bilateral lower extremities, was wheelchair dependent and required total staff assistance for wheelchair mobility and was at risk for decline in ROM. The note indicated a restorative program would be set up in order to prevent any decline. R 72's care plan dated 12/19/14, indicated R72 was transferred with two staff and an E-Z lift and utilized a wheelchair for mobility. The care plan failed to include the restorative nursing program. On 11/6/15, at 1:03 p.m. RN-B confirmed R72's restorative program was not identified on R72's care plan and stated it had just got missed. R203's admission minimum data set (MDS) dated 9/4/15, identified R203 had a severe cognitive impairment and diagnoses which included non-Alzheimer dementia and hypertension. The MDS indicated R203 required extensive assist from staff for bed mobility, transfers, dressing, toileting, and ambulation. R203's physical therapy (PT) discharge note dated 9/11/15, indicated R203 was to walk to meals. R203's Rehabilitative Care sheet dated 9/16/15,	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	11/06/2015

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2 560	Continued From page 3 indicated R203 was to walk to meals and to the bathroom as able with assist of one staff and walker. R203's care plan dated 11/4/15, directed staff to R203 with a front wheeled walker and assist of one staff. The care plan failed to include the restorative nursing program / the frequency of the ambulation. On 11/2/15, at 5:00 p.m. before the dinner meal R203 was observed to be wheeled to the dining room. On 11/4/15 at 7:00 a.m. nursing assistant (NA)-A assisted R203 with morning cares. R203 used a 4 wheeled walker (an assistive walking device) to move from the bed and transfer into her wheel chair, while NA-A and NA-B used a gait belt to assist R203. NA-A wheeled her to the dining room for breakfast. On 11/5/15, at 6:05 a.m. NA-A stated R203 very rarely attempted to self transfer any more and did not go for walks anymore. NA-A stated R203 could walk a couple of steps which involved R203 standing with her walker placed in front of her and taking several steps to the wheelchair or the recliner. NA-A stated R203 really leaned forward and needed to sit down shortly after she stood due to being unsteady. NA-A stated it had been several weeks since R203 had walked to the dining room. On 11/5/15, at 11:25 a.m. RN-A unit manager verified R203's care plan did not include the restorative nursing plan / walking program. RN-A stated R203 was to be on a walking program as recommended by the PT however, the task for the nursing assistants to complete was never put	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00298	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4 into the computer theretofore the NA's were not aware of R203's ambulation program. The Care Planning policy dated 9/2013, directed staff to provide care according to the residents' individual care plan. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures pertaining to the development of resident care plans to assure they comply with the regulations and education staff and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services as directed by the individual care plan for 2 of 2 residents (R99, R23) in the sample who required assistance with oral cares, for 1 of 3 residents (R23) who required assistance perineal cares and for 2 of 2 residents (R122, R65) who were to	2 565	Corrected	11/30/15

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2 565	Continued From page 5 receive restorative nursing rehabilitation services. Findings include: R99 did not receive oral cares as directed by the care plan. R99's care plan dated 12/17/14, directed staff to provide oral swabs for oral cares twice a daily and provide mouthwash. On 11/5/15, from 7:10 a.m. until 7:26 a.m. nursing assistant (NA)-G was observed to assist R99 with morning cares. At no time did NA-G offer R99 oral cares. -At 7:26 a.m. R99 was assisted to the dining room for breakfast. -At 8:50 a.m. after the meal, NA-H assisted R99 from the breakfast table into the restroom. At no time was NA-H observed to offer oral cares. On 11/5/15, at 8:55 a.m. NA-H stated oral cares were to be completed before breakfast. She verified she had not offered or provided R99 oral cares after the meal. On 11/5/15, at 9:14 a.m. NA-G verified she had not offered or provided R99 oral cares and should have during morning cares. On 11/5/15, at 9:20 a.m. registered nurse (RN)-A verified staff should have completed R99's oral cares as directed by the care plan.	2 565		

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2 565	Continued From page 6 R23 did not receive oral cares or perineal cares as directed by the care plan. R23's care plan dated 1/7/15, indicated R23 did not have teeth and directed staff to provide oral cares twice a day. The care plan also directed staff to provide perineal cares after each incontinent episode and to utilize protective skin creams. On 11/5/15, at 6:15 a.m. NA-G was observed to provide R23 with morning cares. R23 was observed to be totally dependent upon staff to complete the task and was unable to verbally communicate. -At 6:20 a.m. NA-H entered the room and assisted NA-G with the cares. -At 6:30 a.m. R23 was transferred from the bed to a wheelchair via a fully body mechanical lift. -At 6:35 a.m. R23 was wheeled to the breakfast table. -At 8:57 a.m. NA-H wheeled R23 from the dining room to her room. NA-G and NA-I assisted R23 transferred R23 to bed. -At 9:00 a.m. NA-H and NA-I were observed to check R23's incontinent brief. R23's incontinent brief was observed saturated with urine. Both NAs removed the brief and applied a new one. At no time were the NAs observed to cleanse R23's perineal area following the incontinent episode nor were the NAs observed to provide R23 oral cares. On 11/5/15, at 9:05 a.m. NA-H stated oral cares were to be completed before the meal and	2 565		

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2 565	Continued From page 7 perineal cares were to be provided after an incontinent episode. NA-H verified she had not provided R23 oral cares or perineal cares as directed by the care plan. On 11/5/15, at 9:15 a.m. NA-G verified she had not completed oral cares during morning cares. On 11/5/15, at 9:20 a.m. RN-A stated oral cares and perineal cares were to be completed as directed by the care plan. R122 did not receive her rehabilitation services six days a week as directed by her care plan/rehab. plan. R122's care plan, dated 11/6/15, directed staff to refer to R122's restorative nursing program plan documentation for specific needs / services to be provided. R122's Restorative program date 3/25/15, indicated R122 was to receive active range of motion (ROM) to right upper extremities due to left sided hemiplegia and weakness. R122's Restorative program dated 5/14/15, included the addition of R122 was to receive splint/brace training to left hand and gentle stretching of left wrist. Both programs were to be completed six days a week. On 11/5/15, at 7:15 a.m. R122 was observed in bed. R122 stated she was to receive rehab services six days a week and she had not been getting the services. R122 stated this week, Mon-Wed. (11/2/15-11/4/15) she had not received rehab services. However, R122 stated yesterday	2 565		

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2 565	Continued From page 8 she had chosen to attend a Christian activity and being she had attended the activity, she could not get rehab services. R122 also stated the rehab department was to be open seven days a week and that was not happening. R122 stated some weeks, the department cut down to being open only three days and someday's they just closed the doors and there was no rehab provided because the rehab staff were pulled to work on the floor. On 11/05/15, at 2:15 p.m. rehab aid/TMA-A verified R122 had not been receiving her rehab as indicated on her restorative plan due to being pulled from the rehab department and having to work on the floor. Rehab aid/TMA-A stated when that happened, the rehab doors were closed and no rehab was provided for any of the residents. On 11/6/15, at 10:20 a.m. RN-B reviewed and verified R122's care plan and rehab directives and stated R122 was to receive the services six days per week as directed. RN-B verified R122 had not been receiving rehab services as directed due to the rehab staff being pulled from the rehab department. R65 did not receive rehabilitation services 6 days a week as directed by her care plan. R65's care plan dated 8/24/15, directed staff to refer to R65's restorative nursing and tasks in point click care (PCC) for specific program information. The program directed staff to provide restorative ambulation which consisted of Nu step level 4's 10 minutes and lower extremity 3 pound	2 565		

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2 565	Continued From page 9 ankle weights-kick and march's 30 repetitions seven day per week. The program also included restorative dressing and grooming which included active ROM bike 200 turns, Red Flex bar 20 repetitions, clothes pin and cord sort 1 time and free weights 30 repetitions which was to be provided six days a week. On 11/5/15, at 7:35 a.m. R65 stated she was not receiving rehab services. R65 stated she was to be receiving the services six days a week and the department was closed both Saturday (10/31/15) and Sunday (11/1/15) and also Monday (11/2/15) and part of Tuesday (11/3/15). R65 stated the rehab staff were pulled to work the floor so they just closed the rehab doors. On 11/5/15, at 8:30 a.m. LPN-F stated there were days when Rehab was closed due to being short of staff and it was usually on the weekends but verified it also happened on some weekdays. LPN-F stated R65 was very loyal to her rehab program and she did not like to miss it. On 11/5/15, at 2:08 p.m. rehab aide/TMA-A stated R65's rehab plan directed R65 to attend six days per week but R65 would come seven days a week. TMA-A verified R65 had not received services as directed by the care plan. On 11/6/15, at 10:20 a.m. RN-B verified R65 had a rehab program which was to be provided six day per week. RN-B confirmed R65 had not received the services as directed by the care plan.	2 565		

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2 565	Continued From page 10 The Care Planning policy dated 9/2013, directed staff to provide care according to the residents' individual care plan. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to following care plans. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by:	2 570		11/30/15

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2 570	Continued From page 11 Based on observation, interview and document review, the facility failed to revise the care plan to include the current passive range of motion (PROM) program for 1 of 5 residents (R23) reviewed for ROM. Findings include: R23's care plan dated 4/8/15, indicated R23 was dependent on staff for all activities of daily living. The plan directed staff to perform restorative nursing services as directed by the nurse manager. The nursing assistant Point of Care (POC) program directed activity staff members to complete PROM which included stretching to the upper and lower extremities for ten repetitions. The goal was to ensure R23 maintained the ability to sit in her wheelchair and hold her daughters hand during visits. The documentation did not direct the staff as to which joints were to receive PROM. On 11/5/15, at 6:10 a.m. NA-G was observed to provide morning cares for R23. NA-G was able to open R23's left hand to wash it. She was able to move the shoulder slightly to wash under it. The left elbow did not extend during cares. NA-G then washed the right side. The right hand was able to open, but the fingers did not extend past 90 degrees. The left elbow did not extended and the left shoulder was able to be moved for R23 in order for the staff to wash under the arm. NA-G stated R23 upper extremities were unable to be fully extended.	2 570	Corrected	

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2 570	Continued From page 12 At 6:15 a.m. NA-H entered the room to assist with cares. NA-H and NA-G completed lower body cares. R23's feet remained in a pointed position (foot drop) as the staff assisted with donning socks. R23's legs were observed to remain together and slightly bent at the knees as the NAs completed perineal cares and donning pants. NA-H stated R23 had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move. NA-H stated R23 had not changed in the past year. On 11/5/15, at 11:26 a.m. R23 was observed to receive passive range of motion from AA-A while seated in her wheelchair. AA-A was observed to gently move R23's hands, elbows and shoulders. AA-A completed repetitive movements on each joint. She was able to fully extend R23's left hand. The left elbow and shoulder did not fully extend. R23's right hand was able to be opened, but the fingers were not observed to be straightened. The elbow and shoulder were moved, but were not observed to be fully extended. At 11:37 a.m. AA-A knelt on the floor and began to do leg exercises for R23. AA-A moved R23's hip and knees while she was seated in the chair. At no time did AA-A observed to attempt to do passive ROM to R23's feet. On 11/6/15, at 8:30 a.m. RN-C verified the care plan needed to be revised to direct the staff how to complete passive ROM for R23. The Care Planning policy dated 9/2013, directed the staff to revise the care plans according to resident need.	2 570		

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2 570	Continued From page 13 A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to the revision of care plans. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to to ensure there was coordination of care for 1 of 1 (R117) resident	2 830	Corrected	11/30/15

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2 830	Continued From page 14 reviewed for hospice services and in addition the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R72) reviewed for wheelchair positioning. Findings include: Hospice R117 was receiving hospice services and the facility and hospice agency had not coordinated the care and services R117 was to receive. R117's medical record progress noted dated 6/10/15, indicated indicated R117 was admitted to Hospice. The record lacked individualized interventions describing how often the hospice home health aide (HHA) would visit, what day the HHA would visit or what services the HHA would provide. R117's quarterly Minimum Data Set (MDS) dated, 9/16/15, indicated R117 diagnoses included cancer, anemia, malnutrition and was terminal. The MDS indicated R117 was totally dependent of staff for all activities of daily living. R117's care plan dated 6/22/15, indicated hospice would direct care for pain/discomfort. R117's hospice care plan for the HHA updated on 9/8/15, indicated a HHA would visit one to two times per week to provide mouth care, fingernail care, peri-care, dressing, transferring, bathing as needed, positioning, toileting, socialization and	2 830		

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2 830	Continued From page 15 tidy room. Facility Contact forms included the visit date, what discipline from the hospice agency visited R117, collaboration with facility staff and next planned visit. A review of R117's Contact forms from 8/17/15, through 11/5/15, revealed the hospice HHA had visited R117 four times as follows: -On 8/26/15, the hospice HHA noted P117 was assisted with lunch. The section for collaboration with facility staff was blank and the section for next planned visit was also blank. -On 9/9/15, the HHA noted R117 was assisted with lunch. The section for collaboration with facility staff was blank and the section for next planned visit was also blank. -On 10/23/15, the HHA had documented collaboration with facility staff but the section for next planned visit was blank. -On 10/30/15, the HHA indicated R117 was sleeping and the facility nurse reported no concerns. The section for collaboration with facility staff was blank and the section for next planned visit was also blank. On 11/5/15, at approximately 2:30 p.m. registered nurse (RN) -B was questioned about coordination of care with hospice staff when the agency visited R117. RN-B stated there was no set schedule and the facility did not know what day, when or how often the hospice HHA made visits. On 11/6/15 at 8:30 a.m. R117 was observed seated in a wheelchair at the dining room table taking a few bites of her breakfast. R117 was non-verbal, eyes were closed most of the time and R117 appeared very lethargic.	2 830		

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2 830	Continued From page 16 On 11/6/15, at 8:30 a.m. nursing assistant (NA)-E was questioned about interventions or cares the hospice HHA provided for R117 when at the facility. NA-E stated there was no set schedule of when the HHA visited and depending on when the HHA came, sometimes they would give R117 an extra bath and if they came at mealtime they might assist R117 with meals. On 11/6/15 at 8:40 a.m. RN-B stated the hospice RN came to the facility last evening, 11/5/15, and explained R117's care plan. The hospice nurse stated the HHA did not have a set schedule for visits because their hospice case load varied so they came when they could. RN-B verified the facility did not know when the hospice HHA staff were coming or what services they would be providing. RN-B confirmed R117's hospice services were not well coordinated or individualized according to R117's needs. On 11/6/15, at 9:08 a.m. R117's hospice nurse was interviewed on the telephone and stated the hospice HHA was supposed to visit R117 every Friday but the time varied depending on the HHA's prior visits of the day and the case load. The nurse indicated the HHA should have collaborated with the facility staff and documented when their next planned visit would be. On 11/6/15, at 9:32 a.m. NA-E stated she worked with R117 most days and was not aware the hospice HHAs visited R117 on Fridays. NA-E also stated she was not aware of the hospice and	2 830		

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2 830	Continued From page 17 facility contact sheet which would have had the dates listed of the next HHA visit. On 11/6/15, at 10:20 a.m. the director of nursing stated hospice agency's used to have a schedule or calendar to indicated when they would be at the facility and if that is not the process now, then something had changed. The facility Hospice Program policy revised January 2014, indicated when a resident participated in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family would be developed and would include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the patient's current status. Wheelchair positioning: R72 required positioning assistance and the facility failed to assist and identify the need for a proper fitting wheelchair. R72's annual Minimum Data Set (MDS) dated 9/7/15, indicated R72 was diagnosed with dementia, osteoarthritis, chronic kidney disease and heart disease. The MDS indicated R72 had cognitive impairment, was non ambulatory, required extensive assist of two staff for transfers and extensive assist of one staff for wheelchair mobility / locomotion on and off the unit. The MDS also indicated R72 was non-ambulatory.	2 830		

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2 830	Continued From page 18 R72's care plan dated 12/19/14, indicated R72 had cognitive impairment and difficulty communicating wants / needs and directed staff to anticipate R72's needs. The plan indicated R72 was transferred with a E-Z mechanical lift and utilized a wheelchair for mobility and directed staff to use foot pedals on the wheelchair if R72 was out of the room or off unit. R72's occupational therapy (OT) care plan dated 7/2/15, and signed by OT-A on 8/9/15, indicated R72 was referred to therapy due to multiple conditions which included dementia, abnormal posturing and a significant decline in wheelchair positioning. The plan indicated R72 required skill therapy to improve functional activities of wheelchair positioning. R72's short term goal dated 7/30/15, indicated R72 would position feet on elevating legs rests in order to maintain proper positioning and comfort. R72's long term goal dated 9/23/15, indicated R72 would maintain proper positioning of legs on elevating leg rest at all times in order to maintain proper positioning and comfort. On 11/06/15, at 10:15 a.m. R72 was observed seated in a wheelchair with feet extended past the leg rests and resting on top of the edge of the foot pedals instead of resting flat on the pedals. A the same time, OT-A who was the director of physical therapy verified R72's feet were not positioned correctly on the foot pedals. OT-A stated R72's wheelchair did not fit him and would need to have a new evaluation for proper wheelchair positioning.	2 830		

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2 830	Continued From page 19 On 11/6/15, at 10:25 a.m. licensed practical nurse (LPN)-D stated R72 had a recent decline and had not wheeled his wheelchair anymore therefore required the use of the foot pedals. LPN-D stated R72 also required total staff assistance for all positioning needs. On 11/6/15, at 10:42 a.m. OT-A stated R72 was evaluated for wheelchair positioning on 7/2/15, and at that time foot rests were added to the wheelchair. OT-A stated the facility should have followed up on the effectives of R72's foot pedals one month after they were initiated, but it had slipped through the cracks. On 11/6/15, at 10:55 a.m. R72 was observed seated in a wheelchair in the television room. One of R72's feet was resting on top of the foot pedal and the other foot had slid off the side of the foot pedal and was resting on the floor. On 11/6/15, at 12:50 p.m. the physical therapist stated an evaluation of R72's lower extremities was just completed and it was determined R72 had motion available in the lower extremities but was resistive to range of motion. The PT stated R72's feet were appropriately placed on the foot rest but R72 did not leave them there. On 11/6/15, at 1:03 p.m. registered nurse (RN)-B stated R72's knees had gotten stiffer and was not sure if the arthritis had worsened or if R72 was declining in range of motion. RN-B confirmed R72's foot pedals were not appropriate for him and stated R72 would be evaluated by OT for	2 830		

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2 830	Continued From page 20 wheelchair positioning. RN-B stated R72 would also be assessed by nursing to determine if R72's pain medication for stiffness of the knees needed to be increased or changed. A policy and procedure for wheelchair positioning was requested but was not provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to monitoring resident wheelchair positioning and coordination of hospice services. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion	2 895		11/30/15

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2 895	Continued From page 21 receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) ability for 3 of 3 residents (R23, R72, R122) in the sample who had limitations in range of motion. Findings include: R23 did not receive range of motion services to minimize limitations in range of motion. R23's quarterly Minimum Data Set (MDS) dated 9/29/15, indicated R23 had dementia, aphasia (loss of ability to understand or express speech), severe cognitive impairment, had limited ROM on one side of the upper body and required total staff assistance with all activities of daily living. R23's annual MDS dated 6/29/15, also identified R23 as having limited ROM on one side of her upper body. R23's Nursing Assessment dated 9/28/15, indicated R23 had limitations in ROM on one side of her upper extremity and had no limitations in her lower extremities. R23's care plan dated 4/8/15, indicated R23 was	2 895	Corrected	

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2 895	Continued From page 22 dependent upon staff for all activities of daily living and directed staff to perform restorative nursing program services as directed by the nurse manager. R23's nursing assistant Point of Care (POC) program directed the activity staff to provide R23 passive ROM exercises which included stretching to the upper and lower extremities for ten repetitions each. The goal was to ensure R23 maintained the ability to sit in her wheelchair and hold her daughters hand during visits. Review of the Restorative Passive ROM documentation for October 2015, indicated R23 had revived ROM for 20 minutes six days a week. The documentation did not identify which joints or limbs received the ROM. Review R23's clinical record lacked progress notes related to R23's progress or regression of her restorative program. On 11/4/15, at 7:08 a.m. nursing assistant (NA)-F and NA-H were observed to transfer R23 from bed into a wheelchair via a full body mechanical lift. R23's hands were observed to be in a closed (loose) fisted position. R23 was not observed to move her arms or her legs independently throughout the observation. -At 7:15 a.m. NA-H was observed to apply bilateral sleeve protectors to R23's arms. R23 did not assist in the application. NA-H applied a sweater in which R23's shoulders and elbows were not observed to extend to assist with the application of the sweater. R23's hands remained	2 895		

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2 895	Continued From page 23 in a closed position during the application of the sleeves and sweater. On 11/4/15, at 7:53 a.m. NA-F was observed to feed R23 the breakfast meal. R23 was not observed to move her upper extremities and was totally dependent upon the staff for meal. -At 9:15 a.m. NA-G and NA-F were observed to transfer R23 from the chair to bed via the mechanical lift. Once in bed, NA-G and NA-F provided R23 with incontinence cares. R23's legs were observed slight bent at the knees and clamped together and her feet were observed to be in a pointed downward position (foot drop). On 11/4/15, at 1:10 p.m. activity aide (AA)-A stated R23 received passive ROM six days a week during activities. AA-A stated the activity staff completed arm and leg repetitions for about 20 minutes each day. AA-A also stated R23's arms and legs had been "tight" but were much better and R23 seemed stronger after receiving the assistance with ROM. On 11/5/15, at 6:10 a.m. NA-G was observed to provide morning cares for R23. NA-G was able to open R23's left hand and wash it and move R23's left shoulder slightly to wash under it. The left elbow did not extend during cares. NA-G was also able to open R23's right hand to wash, however, R23's fingers did not extend past 90 degrees. R23's right elbow did not extend and the shoulder was able to be moved to allow for cleansing. NA-G stated R23's upper extremities were unable to be fully extended. -At 6:15 a.m. NA-H entered the room to assist	2 895		

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2 895	Continued From page 24 with cares. NA-H and NA-G both completed R23's lower body cares. R23's feet remained in a foot drop as staff assisted with donning socks. R23's legs were observed to remain together and slightly bent at the knees as the NAs completed perineal cares and applied R23's pants. NA-H stated R23 had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move. NA-H stated R23 had not changed in the past year. On 11/5/15, at 9:20 a.m. registered nurse (RN)-D stated she completed the MDS but did not complete bedside ROM assessments on dependent residents'. RN-D stated all MDS coding was transcribed from the Nursing Assessment which was completed by the RN-A -At 9:25 a.m. RN-D was observed to complete ROM for R23 while R23 was in bed. RN-D stated R23 displayed bilateral upper and lower limitations in range of motion in the shoulders, elbows, hands and hips, knees and feet. -At 9:40 a.m. RN-D verified the MDS was not coded correctly as it did not identify R23's limitations in ROM in both upper and lower extremities. At the same time, RN-A verified she had completed R23's 9/28/15, Nursing Assessment, and stated at that time, R23 only had limitations on one side of her body. RN-A stated she completed the ROM assessment at the bedside for all dependent residents. On 11/5/15, at 11:26 a.m. AA-A was observed to perform passive ROM exercises for R23 while R23 was seated in the wheelchair. AA-A was observed to gently move R23's hands, elbows	2 895		

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2 895	Continued From page 25	2 895		

and shoulders. AA-A completed repetitive movements on each joint. She was able to fully extend R23's left hand. The left elbow and shoulder did not fully extend. R23's right hand was able to be opened, but the fingers were not observed to be straightened. The elbow and shoulder were moved, but were not observed to be fully extended.
-At 11:37 a.m. AA-A knelt on the floor and began to do leg exercises for R23. AA-A moved R23's hip and knees while she was seated in the chair. At no time was AA-A observed to attempt to do passive ROM to R23's feet.
-At 11:43 a.m. AA-A completed the cares.

On 11/5/15, at 11:45 a.m. AA-A stated a former RN had trained her to complete ROM exercises. She stated she had been assisting R23 with ROM for greater than a year. AA-A verified R23 had limitations in ROM ability but they had not changed in the past year. She verified at no time did she complete ROM to R23's feet.

On 11/5/15, at 11:50 a.m. RN-A stated she had observed AA-A perform ROM exercises but had not completed any type of documentation related to AA-A's ROM program / services. RN-A stated AA-A would report any concerns of ROM to her.

On 11/5/15, at 2:20 p.m. RN-A stated the identified concerns related to R23's limited ROM abilities were all new since 9/28/15. She stated RN-C was in charge of the restorative program and any concerns would be identified in RN-C's documentation.

On 11/5/15, at 2:30 p.m. RN-C stated she was

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2 895	Continued From page 26	2 895		

the restorative program liaison. She stated staff members met on a monthly basis to review the restorative program. RN-C stated AA-A had not attended the restorative meetings nor provided feedback related to the residents' receiving ROM from the activity staff. RN-C stated any documentation related to the restorative programing completed by AA-A would be up to RN-A to complete. RN-A verified she had not completed restorative reviews on AA-A's residents including R23. The surveyor requested for RN-C to locate any therapy documentation related to R23's restorative program as the current medical record did not contain therapy evaluations.

On 11/6/15, at 8:30 a.m. RN-C verified RN-D completed the MDS assessment but did not go onto the nursing units to perform ROM assessments. She stated RN-D was to complete the MDS according to the Nursing Assessment documentation. RN-C stated the Nursing Assessment completed on 9/28/15, would have been the assessment used for the completion of the quarterly MDS dated 9/29/15. RN-C stated RN-D would have only went on to the nursing units and personally assessed a resident only when needed to check areas of concern if the documentation contraindicated itself. She stated RN-D was not expected to complete ROM for R23 prior to the completion of an MDS.

On 11/6/15, at 8:42 a.m. RN-D reported she had located R23's past therapy evaluations. The Physical Therapy Evaluation dated 3/27/13, indicated R23 had bilateral limitations in ROM in the lower extremities including hips, knees and feet. On 6/28/14 a passive ROM program was initiated at which time R23 was identified with bilateral imitations in her shoulders, arms and

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2 895	Continued From page 27 hands. RN-D also provided email communication dated 10/16/14, between herself and RN-A in which RN-A indicated R23 was no longer able to move her feet. On 11/6/15, at 8:45 a.m. RN-C stated R23 should be receiving ROM to her feet in order to prevent further foot drop. -At 8:47 a.m. RN-D stated she had interviewed several long term staff members who all indicated R23's ROM had not changed in the past year. - At 9:00 a.m. RN-C stated the facility restorative program policy directed the unit mangers to monitor the residents' ROM program to ensure they were receiving the necessary services to maintain/prevent further decline. R72 did not receive range of motion services to minimize limitations in range of motion. R72's annual MDS dated 9/17/15, indicated R18 was diagnosed with dementia, osteoarthritis and had severe cognitive impairment, bilateral lower extremity limitations in ROM and did not walk. R72's care plan dated 12/19/14, indicated R72 utilized a wheelchair and was transferred with two staff and an E-Z mechanical lift. The care plan did not identify a nursing restorative program. R72's medical record included a restorative program note dated 9/9/15, written by RN-B and had late entry next to the date. The note described R72 as having limitations to bilateral lower extremities in both knees. The note indicate R72 was able to flex and extend, invert and avert ankles, hips and all other joints of the lower extremities. The note indicated R72 was at risk	2 895		

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2 895	Continued From page 28 for decline in ROM, was wheelchair dependent and required staff assist to propel to all destinations. The further indicated a restorative program would be set up in order to prevent any decline and R72 would be re-evaluated next quarter. R72's medical record indicated on 9/5/15, RN-B initiated a new restorative program for R72 for the NAs to complete. The program consisted of passive range of motion six times per week and directed staff to provide abduction, adduction, flexion and extension to bilateral shoulders, elbows, wrist, fingers, hips, knees, ankles and toes daily. On 11/06/15, at 10:15 a.m. R72 was observed seated in a wheelchair with both legs extended straight out and resting on top of the foot pedals, not on the foot pedals. On 11/6/15, at 10:25 a.m. licensed practical nurse (LPN)-D stated R72 had a recent decline in which R72 no long wheeled own wheelchair, hardly fed himself like he used to an required total staff assist for all positioning needs. R72's monthly rehab schedule was reviewed and indicated PROM was only completed two times in September on 9/6/15, and 9/20/15. There was no record PROM was competed in October or November. On 11/6/15, at 1:03 p.m. RN-B stated a task form was completed in R72's medical record to direct nursing staff to complete and sign off when	2 895		

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2 895	Continued From page 29 completed. RN-B confirmed R72's PROM was only signed off as being completed only twice. RN-B verified R72's record had no other documentation which indicated ROM had been provided to R72. R122 did not receive range of motion services to minimize limitations in range of motion (ROM) as directed by the care plan. R122's quarterly MDS dated 8/20/15, indicated R122 was diagnosed with hemiplegia (paralysis on one side of the body) and anxiety. The MDS also indicated R122 had intact cognition, limited ROM on one side of the upper / lower body and required extensive assistance with all activities of daily living. R122's Activities of Daily Living CAA dated 2/23/15, indicated R122 had a fall while living in assisted living and sustained a head injury and had a stroke many years ago which resulted in the hemiparesis on the left side. The CAA indicated R122 was receiving physical therapy (PT) and occupational therapy (OT) for rehabilitation and at that time R122 was taking 3 steps in physical therapy. R122's care plan, dated 11/6/15, directed staff to refer to nursing restorative documentation for program specifics. R122's restorative program dated 3/25/15, indicated R122 was to receive active ROM services to the upper extremities. R122's restorative program dated 5/14/15, indicated R122 was to receive splint / brace training to the left hand and gentle stretching of left wrist. Both programs were to be provided six	2 895		

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2 895	Continued From page 30 days per week. On 11/5/15, at 7:15 a.m. R122 was observed in bed. R122 stated she was to receive rehab services six days a week and she had not been getting the services. R122 stated this week Mon-Wed. (11/2/15-11/4/15) she had not received rehab. However, R122 stated yesterday she had chosen to attend a Christian activity and being she had attended the activity, she did not get rehab services. R122 also stated the rehab department was to be open seven days a week and that was not happening. R122 stated some weeks, the department cut down to being open only three days a week and someday's they just closed the doors and there was no rehab provided because the rehab staff were pulled to work on the floor. On 11/05/15, at 2:15 p.m. the rehab/ trained medication aide (TMA)-verified R122 had not received rehab services as directed on her restorative plan due to being pulled from the rehab department and having to work on the floor. Rehab aid/TMA-A stated when that happened, the rehab doors were closed and no rehab was provided for any of the residents. On 11/6/15, at 10:20 a.m. RN-B reviewed and verified R122's care plan and rehab directives and stated R122 was to receive the services six days per week as directed. RN-B verified R122 had not received rehab services as directed due to the rehab staff being pulled from the rehab department.	2 895		

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2 895	Continued From page 31 The undated, Restorative Care Policy indicated the objective was directed toward assisting each resident to achieve and maintain their highest level of self-care through positioning, range of motion and ambulation. The policy also indicated the residents' would be assessed at time of admission by PT/OT whereby PT/OT would determine goals and level of restorative care upon discharge from PT/OT therapy services. The Care Planning policy dated 9/2013, directed staff to provide care according to the residents' individual care plan. Suggested Method of Correction: The Director of Nursing or designee could assign the interdisciplinary team to review all residents limitations in range of motion to assure they are receiving the necessary treatment/services to maintain their range of motion ability. The facility could consider having the Medical Director provide oversite for all resident with limitations in range of motion. The Quality Assurance Committee could provide on-going monitoring of the delivery of care to residents to assure they are being offered services or treatments. Time Period for Correction: Twenty-one (21) days.	2 895		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate	2 915		11/30/15

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	00298	A. BUILDING: _____ B. WING _____	11/06/2015

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2 915	Continued From page 32 treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 1 of 1 resident (R203) in the sample reviewed for restorative nursing ambulation services and for 1 of 1 resident (R65) in the sample reviewed for rehab nursing services. Findings include: R203's admission Minimum Data Set (MDS) dated 9/4/15, indicated R203 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance from staff for bed mobility, transfers, dressing, toileting and ambulation. R203's Activities of Daily Living Care Area Assessment dated 9/11/15, indicated R203 had received physical therapy (PT) and	2 915	Corrected	

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2 915	Continued From page 33 occupational therapy (OT) to increase strength and independence. R203's PT discharge therapy note dated 9/11/15, indicated R203 was to walk to meals. R203's Rehabilitative Care sheet dated 9/16/15, indicated R203 was to walk to meals and to the bathroom as able with assist of one staff and walker. R203's care plan, dated 11/4/15, indicated R203 was to ambulate with a front wheeled walker and assist of one staff. However, the plan did not address R203's restorative program. On 11/2/15, at 5:00 p.m. staff were observed to wheel R203 into the dining room. On 11/4/15 at 7:00 a.m. nursing assistant (NA)-A was observed to assist R203 with morning cares. NA-A applied a transfer belt around R203's waste and assisted R203 as she utilized a four wheeled walker (an assistive walking device) to transfer self from the bed and into the wheelchair. NA-A wheeled R203 to the dining room for breakfast. On 11/5/15, at 6:05 a.m. NA-A stated R203 very rarely attempted to self transfer any more and no longer went for walks. NA-A stated R203 could walk a couple of steps such as standing with her walker in front of her and transferring taking several steps to the wheelchair or the recliner.	2 915		

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2 915	Continued From page 34 NA-A stated R203 really leaned forward when standing and needed to sit down shortly after she stood up due to being unsteady. NA-A stated it had been several weeks since R203 had walked to the dining room. On 11/5/15, at 11:25 a.m. RN-A verified R203 was to be on a walking program as recommended by the PT however, the task directive for the NAs to follow was never put into the computer. RN-A stated she had seen R203 walk with one staff and walker from the day room to the dining room on 10/29/15. At this time, NA-A was asked to walk R203. R203 was observed to slowly walk from the day room into the dining room. Following this observation, RN-a stated she was going to in-put R203's PT recommendation for the ambulation program into the computer so that the NAs would have to document R203's ambulation each day. R65 did not receive range of motion/rehab services as directed on the care plan/nursing restorative program. R65's admission MDS dated 8/31/15, indicated R65 was diagnosed with diabetes, congestive heart failure and degenerative joint disease. The MDS also indicated R65 had intact cognition and was independent in ambulation, bed mobility and required limited assist with dressing. R65's Activities of Daily Living Care Area Assessment dated 9/11/15, indicated R65 was currently participating in rehab nursing services for active range of motion (AROM) and walking. The MDS indicated during the MDS reference period R65 had received seven days of rehab nursing services.	2 915		

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2 915	Continued From page 35 R65's Physical Therapy Plan of care dated 1/16/15, indicated R65 had been referred due to weakness status post coronary angiography. R65's care plan dated 8/24/15, directed staff to refer to R65's restorative nursing and tasks in point click care (PCC) for specific program information. The Restorative plan dated 8/24/25, indicated staff were to provide R65 ambulation, Nu step level 4's 10 minutes and lower extremity three pound ankle weights/kick and march 30 repetitions seven days per week. In addition staff were directed to provide a restorative dressing and grooming program which was dated 12/15/14, and included active ROM on bike 200 turns, Red Flex bar 20 reps, clothes pin and cord sort once and free weights for 30 reps. The program was to be completed 6 days a week. R65's Functional/Safety Assessment dated 9/1/15, indicated R65 was currently receiving rehab nursing every day to maintain her ability in full ROM. On 11/5/15, at 7:35 a.m. R65 stated she was not receiving rehab services. R65 stated she was to be receiving the services six days a week and the department was closed both Saturday (10/31/15) and Sunday (11/1/15) and also Monday (11/2/15) and part of Tuesday (11/3/15). R65 stated the rehab staff were pulled to work the floor so they just closed the rehab doors. On 11/5/15, at 8:30 a.m. LPN-F stated there were	2 915		

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2 915	Continued From page 36 days when Rehab was closed due to being short of staff and it was usually on the weekends but verified it also happened on some weekdays. LPN-F stated R65 was very loyal to her rehab program and she did not like to miss it. On 11/5/15, at 2:08 p.m. rehab aide/TMA-A verified R65's rehab plan directed R65 to attend six days per week but stated R65 would come seven days a week. TMA-A verified R65 had not received services as directed by the care plan as the rehab person had been pulled from the rehab department quite a bit. The rehab staff schedule was reviewed with rehab aide/TMA-A and the following was revealed: -10/3/15, no rehab staff, department was closed. -10/4/15, no rehab staff, department was closed. -10/5/15, rehab staff pulled at 8:30 a.m. to work the floor for the day. -10/10/15, no rehab staff available, department closed -10/13/15, staff was pulled from the department -10/17/15, rehab staff was pulled form the department and she quit. -10/18/15, no rehab staff available, department closed -10/27/15, rehab staff were pulled from the department all day -10/29/15, pulled all day -10/30/15, pulled until 10:15 a.m. -10/31/15, pulled all day -11/1/15, pulled all day -11/2/15, pulled all day -11/3/14, staff was pulled from the department from 8:00 a.m.-10:30 a.m.	2 915		

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2 915	Continued From page 37 On 11/6/15, at 10:20 a.m. RN-B verified R65 had was to receive rehab / restorative services as directed stated it was more for R65's maintenance and strengthening program which was to be provided six days per week. RN-B confirmed R65's care plan was not being followed. The undated, Restorative Care Policy indicated the objective was directed toward assisting each resident to achieve and maintain their highest level of self-care through positioning, range of motion and ambulation. The policy also indicated the residents' would be assessed at time of admission by PT/OT whereby PT/OT would determine goals and level of restorative care upon discharge from PT/OT therapy services. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with restorative rehabilitative services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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2 920	Continued From page 38	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 2 of 2 residents (R23, R99) in the sample who were dependent on staff for oral hygiene. In addition the facility failed to complete perineal cares for 1 of 1 resident (R23) who was incontinent of urine and dependent upon staff for perineal cares. Findings include: R99 did not receive oral cares as directed by the care plan. R99's significant change Minimum Data Set (MDS) dated 9/4/15, indicated R99 was diagnosed with dementia, anxiety and seizure disorder. The MDS also indicated R99 had cognitive impairment, had no teeth and required extensive to total assistance with all activities of daily living. R99's Dental Care Area Assessment (CAA) dated 9/15/15, indicated R99 did not have teeth but was a risk for issues with chewing food, bleeding and infection. The CAA indicated staff	2 920	Corrected	11/30/15

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2 920	Continued From page 39 provided R99 oral cares daily and as needed by using half strength mouthwash and oral swabs daily. R99's care plan dated 12/17/14, directed staff to utilize oral swabs for oral cares twice a daily and provide mouthwash. On 11/5/15, from 7:10 a.m. until 7:26 a.m. nursing assistant (NA)-G was observed to assist R99 with morning cares. At no time did NA-G provide or offer R99 oral cares. -At 7:26 a.m. R99 was assisted to the dining room for breakfast. -At 8:50 a.m. NA-H assisted R99 from the breakfast table to the restroom. At no time was NA-H observed to offer or provide R99 oral cares. On 11/5/15, at 8:55 a.m. NA-H stated oral cares were to be completed before breakfast. She verified she had not offered oral cares after the meal. On 11/5/15, at 9:14 a.m. NA-G verified she had not offered or provided R99 oral cares and stated she should have provided oral cares during morning cares. On 11/5/15, at 9:20 a.m. registered nurse (RN)-A verified staff should have completed oral cares as directed by R99's care plan. R23 was not provided oral cares or perineal cares as directed by the care plan.	2 920		

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2 920	Continued From page 40 R23's quarterly MDS dated 9/29/15, indicated R23 had dementia, severe cognitive impairment, was incontinent of bladder and required required total assistance with all activities of daily living including oral cares. R23's care plan dated 1/7/15, indicated R23 had no teeth and directed staff to provide oral cares twice a day. The plan also directed staff to provide perineal cares after each incontinent episode and to utilize protective skin creams. On 11/5/15, at 6:15 a.m. NA-G was observed to provide R23 with morning cares. R23 was observed to be totally dependent upon staff to complete the task and was unable to verbally communicate. -At 6:20 a.m. NA-H entered the room and assisted NA-G with the cares. -At 6:30 a.m. R23 was transferred from the bed to a wheelchair via a fully body mechanical lift. -At 6:35 a.m. R23 was wheeled to the breakfast table. -At 8:57 a.m. NA-H wheeled R23 from the dining room to her room. NA-G and NA-I assisted R23 transferred R23 to bed. -At 9:00 a.m. NA-H and NA-I were observed to check R23's incontinent brief. R23's incontinent brief was observed saturated with urine. Both NAs removed the brief and applied a new one. At no time during the observations were the NAs observed to cleanse R23's perineal area following the incontinent episode nor were the NAs observed to provide R23 oral cares.	2 920		

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2 920	Continued From page 41 On 11/5/15, at 9:05 a.m. NA-H stated oral cares were to be completed before the meal and perineal cares were to be provided after an incontinent episode. NA-H verified she had not provided R23 oral cares or perineal cares as directed by the care plan. On 11/5/15, at 9:15 a.m. NA-G verified she had not provided R23 oral cares during morning cares. On 11/5/15, at 9:20 a.m. RN-A stated oral cares were to have been completed during morning cares as directed by the care plan. She also stated perineal cares were to be completed following each incontinent episode. The Mouth Care policy dated 10/2010, directed staff to provide oral cares to ensure the residents lips and oral tissues were moist, to cleanse and freshen the resident's mouth and to prevent infections of the mouth. The Perineal Care polity dated 10/2010, directed the staff to provide perineal cares following each incontinent episode. Suggested Method for Correction: The Director of Nursing (DON) or designee could review and revise policies and procedures related to the provision of oral hygiene cares. The DON or designee could education staff and develop a monitoring system to ensure compliance. The quality assurance committee could randomly audit resident's cares to ensure compliance.	2 920		

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2 920	Continued From page 42 Time Period for Correction: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident with anticipated nutritional decline received nutritional supplementation according to the assessed need and preference in order to minimize weight loss for 1 of 3 (R203) residents reviewed for nutrition. Findings include: R203's admission Minimum Data Set (MDS) dated 9/4/15, indicated R203 had dementia and a severe cognitive impairment. The MDS also indicated R203 weighed 149 pounds and required supervision from staff while eating. R203's medical record revealed the following:	2 965	Corrected	11/30/15

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2 965	Continued From page 43 -on 8/29/15, R203 weighed 149 pounds (lbs.) -on 9/12/15, weighed 145 lbs. -on 10/25/15, weighed 140 lbs. -on 11/2/15, 137 lbs. R203's Dietician Progress note dated 10/27/15, indicated R203 had a weight loss and was started on 4-6 ounce house or house juice supplementation three times a day between meals. R203's physician's order dated 10/27/15, indicated R203 was started on a house supplement or juice supplement 4-6 ounces three times a day between meals. R203's Nurse Progress noted dated 11/3/15, and completed by registered nurse (RN)-A indicated R203's weight was almost 10 pounds less than her baseline weight. The dietitian had been alerted on that date and R203 was started on a house supplement three times a day on 10/27/15, with the hope R203's weight returned to baseline soon. However, the supplement was never started. On 11/4/15, from 7:30 a.m. until 8:30 a.m. R203 was observed in the dining room eating breakfast. R203 consumed several bites of toast, a cup of hot chocolate and three ounces of apple juice. R203 had been very busy talking to herself and did not appear interested in eating. On 11/5/15, at 6:10 a.m. licensed practical nurse (LPN)-B stated she was not aware R203 was to	2 965		

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2 965	Continued From page 44 receive a nutritional supplement. LPN-A reviewed R203's Treatment Administration Record (TAR) which would have identified the need to provide R203 a supplement, stated the TAR had not indicated R203 was to receive and no directive to provide R203 a nutritional supplement. LPN-A stated she had not provided R203 a supplement when she worked the day shift. On 11/5/15, at 11:15 a.m. RN-A verified the dietitian had written an order for R203's supplement on 10/27/15, however stated it was never started because the order was in-putted into the computer wrong. A policy, Medical Nutrition Therapy (MNT) Recommendations, undated, indicated MNT recommendations from the registered dietitian/dietetic technician would be implemented or reason for non-implementation would be documented. Any recommendations, which need nursing's attention or a physician's order, would be forwarded in writing to the nursing staff. Suggested Method of Correction: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents receive appropriate assistance to maintain nutrition as determined necessary by their individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance.	2 965		

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2 965	Continued From page 45 Time Period for Correction: Twenty-one (21) days.	2 965		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate procedures were implemented in order to maintain appropriate holding temperatures of hard boiled eggs when served from the resident salad cart. The facility also failed to implement appropriate food temperature procedures related to cleaning the probe in between food items temped. These practices had the potential to affect all 111 residents in the facility who received food from the kitchen and / or salad cart. Findings include: Norway dining room: On 11/2/15, at 5:00 p.m. nursing assistant (NA)-K was observed in the Norway dining room with a salad cart. The cart was observed to contain a large bowl of lettuce and several smaller bowls	21025	Corrected	11/30/15

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21025	Continued From page 46 which contained boiled pasteurized eggs, cheese, carrots, pickled beets, cucumbers and sunflower seeds. The cart did not have a system to ensure the salad toppings were kept cool prior to service. -At 5:03 p.m. NA-K began to wheel the salad cart from table to table asking the residents in the dining room if they wanted a salad and assisted them to build a salad of their choice. At this time, the surveyor approached NA-K and requested the temperature of the boiled eggs be checked. The eggs were found to be 48 degrees Fahrenheit (F). NA-K stated the salad cart had been prepared by the dietary staff and arrived on the Norway neighborhood between 4:00 - 4:15. NA-K verified the salad cart contained boiled eggs which should be kept cool when served and stated the facility did not have a system in place to ensure the items remained cool. NA-K removed the boiled eggs from the salad cart. Wolf/Moose Lodge Dining Room: On 11/2/15, at 5:20 p.m. the nursing staff in the Moose / Wolf dining room were observed wheeling a salad cart into the kitchen. The nursing staff stated they had just finished offering all the residents in the dining room a salad. The cart was observed to contain a large bowl of lettuce and several smaller bowls that contained boiled pasteurized eggs, cheese, carrots, pickled beets, cucumbers and sunflower seeds. At this time, cook (C)-A checked the temperature of the eggs which measured 48 degrees F. The dietary manager stated staff had taken the food items out of the refrigerator earlier and wheeled them on to the Lodge/Wolf dining room.	21025		

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21025	Continued From page 47 On 11/4/15, at 11:59 a.m. NA-C was observed wheeling a salad cart with a large bowel of salad and several other salad items which were set in a larger bowel that was filled with ice. NA-C stated the ice was something new and the kitchen staff had set up the cart with salad items being placed on ice. The undated Storage of Good policy directed staff to ensure cold food was maintained at 32-40 degrees and an internal thermometer was to be kept in all refrigerators and freezers. Woods Dining room: On 11/04/2015, at 11:28 a.m. DA-A was observed to pick up the food service tray from the main kitchen for the Woods dining room lunch meal. DA-A was observed to place the food containers into the steam table. DA-A used a yellow food thermometer probe to obtain food temperatures. DA-A inserted the probe into the chicken nuggets without cleaning the probe first. DA-A inserted the same probe into the chicken breast (186 degrees) Fahrenheit (F) at which time DA-A wiped the probe off with a paper towel. DA-A proceeded to check the temperature of the rice (195 F) and the sweet and sour sauce (195 F). DA-A rinsed the thermometer probe under running water at the sink and wiped it off with a paper towel. DA-A proceeded to temp the broccoli (178 F), followed with the mashed potatoes (182 F). DA-A wiped the thermometer probe off with a paper towel. DA-A temped the hamburger patties and wiped the probe off with a paper towel then proceeded to temp the gravy (187 F). DA-A	21025		

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21025	Continued From page 48 rinsed the thermometer off under running water and wiped off the probe with a paper towel. DA-A checked the temp of the lettuce (38 F) and cheese (40 F). DA-A was not observed to clean the thermometer probe between foods. On 11/4/15, at 12:57 p.m. DA-A stated, " I am suppose to use the wipes to clean the thermometer probe after each food, and I did not do that." On 11/4/15, at 2:05 p.m. the DM stated food sanitizing wipes should have been utilized to cleanse the thermometer probe between each food item. However, the DM stated she was aware some of the neighborhoods were out the proper probe cleansing wipes so staff should have used alcohol wipes to clean the probes in between each food item until the probe cleansing wipes came in. The undated, Cleaning Instructions: Thermometers policy indicated thermometers would be cleaned and sanitized before and after each use.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		11/30/15

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21390	Continued From page 49 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain infection control standards related to the use of personal protective gloves and appropriate disinfecting of community use glucometers in 8 of 8 neighborhoods who utilized community glucometers. In addition, the facility failed to ensure proper hand hygiene and glove use was performed during the administration of eye medication for 1 of 3 eye medication administration observations (R122). Findings include:	21390	Corrected	

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21390	Continued From page 50 Glucometer: Norway neighborhood: On 11/2/15, at 4:45 p.m. licensed practical nurse (LPN)-G was observed to approach R65 while caring a glucometer (blood glucose machine) in the Norway dining room. LPN-G did not apply gloves as she proceeded to check R65's blood sugar. Following the blood sugar check, LPN-G placed the glucometer into a caring basket and returned the glucometer to the top of the medication cart. LPN-G left the medication cart and answered a call light on the nursing unit. At no time was LPN-G observed to apply gloves while completing the glucose monitoring, sanitize the glucometer or wash her hands after completing the procedure. On 11/2/15, at 5:10 p.m. LPN-G stated the glucometer was utilized for three residents who resided on the Norway neighborhood and was to be cleaned at the end of each shift. She verified she did not wear gloves while checking R65's blood sugar as R65 did not like gloves when cares were provided. She verified she did not clean the machine and did not wash her hands after the procedure. On 11/2/15, at 5:23 p.m. LPN-M stated the glucometers were to be cleansed with a germicidal "Sani" wipe after each use. On 11/3/15, at 9:44 a.m. LPN-H stated the glucometer on the Norway unit was utilized for R65, R13 and R185. LPN-H stated the	21390		

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21390	Continued From page 51 glucometer was to be cleaned after each use. In addition, LPN-H stated she routinely utilized gloves while completing glucose monitoring for R65. She stated at no time had R65 had any type of issues with the staff utilizing gloves during procedures. On 11/5/15, at 9:48 a.m. registered nurse (RN)-A stated the staff were to wear gloves and cleanse the glucometers after each use. Moose / Wolf Lodge neighborhood: On 11/2/15, at 4:45 p.m. LPN-L was observed to complete R41's blood glucose test. LPN-L did not apply gloves as she proceeded to check R41's blood sugar. LPN-L then wiped the glucometer with an alcohol wipe, placed the glucometer into a caring basket and returned the glucometer to the top of the medication cart. At 5:00 p.m. LPN-L completed a blood sugar check on R218. LPN-L did not apply gloves as she proceeded to check R218's blood sugar. LPN-L then wiped the glucometer machine with an alcohol wipe, placed the glucometer into a caring basket and placed it on top of the medication cart. At that time LPN-L stated the glucometer machine was used for all the residents on the Moose/Wolf Lodge and was to be cleaned between residents with an alcohol wipe. On 11/6/15, at 8:20 a.m. RN-B stated the staff should be utilizing gloves while completing	21390		

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21390	Continued From page 52 glucometers and the machines were to be cleaned after each use according to the facility policy. On 11/6/15, at 10:30 a.m. the DON gave the surveyor a paper that stated, "Effective Immediately" each resident would be given their own glucometer. The meter was to stay in a labeled bag for each resident, all meters would be calibrated prior to use and nightly. For residents who had not yet been supplied a personal meter, staff would need to disinfect the community meter between all residents with a sani-wipe. Aspen and Birch neighborhood: On 11/5/15, at 7:51 a.m. LPN-D was observed to remove a TrueTRACK glucometer from the medication cart. LPN-D obtained a glucometer test strip, inserted in the glucometer and obtained R38 blood sugar and place the glucometer on top of the medication cart. LPN-D was not observed to clean the glucometer before or after use. At 9:13 a.m. R61 stopped at LPN-D's medication cart and requested to have his blood sugar tested. LPN-D picked up the glucometer from the top of the medication cart and inserted a test strip into the glucometer, obtained R61's blood glucose and returned the glucometer to the top of the medication cart. LPN-D was not observed to clean the glucometer prior to use or following use. At 9:20 a.m. LPN-D verified the glucometers were to be cleaned with a Sani wipe after each use and stated she had not cleaned the glucometer as she should have.	21390		

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21390	Continued From page 53 On 11/5/15, at 11:24 a.m. RN-B verified the glucometer utilized by staff to obtain glucose monitoring on the Aspen and Birch units was a community glucometer and it was facility policy to clean the machine after each resident use. RN-B stated it was here expectation for staff to be following our facility policy. On 11/6/15, at 8:17 a.m. RN-E stated the Spruce neighborhood utilized just one community TRUEtrack glucometer for checking blood sugars for residents.. At 9:16 a.m. LPN-K stated the Wolf neighborhood had just one community TRUEtrack glucometer used for checking resident blood sugars on this unit. At 10:15 a.m. LPN-G stated Norway neighborhood had just one community TRUEtrack glucometer to used on the unit. At 10:30 a.m. LPN-A stated the Rivers neighborhood had just one community TRUEtrack glucometer to use for checking blood sugars. At 10:40 a.m. trained medication assistant (TMA)-B on the Waters unit stated her supervisor completed the blood sugar checks, however verified the Waters neighborhood had just one community TRUEtrack glucometer. The TRUEtrack glucometer manufactures owner's booklet, dated 2014 indicated for patients important health and safety information, WARNING! The TRUEtrack Blood Glucose Monitoring System was for one person use only. DO NOT share your Meter or your Lancing	21390		

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21390	Continued From page 54 Device with anyone, including family members. ALL parts of your Blood Glucose Monitoring System could carry blood-borne diseases after use, even after cleaning and disinfection. The Blood Sampling - Capillary (Finger Stick) policy dated 2014, directed staff to always ensure the blood glucose monitoring meters intended for reuse were cleaned and disinfected between resident uses. Single-resident use fingerstick devises should never be used by more than one resident. On 11/6/15, at 11:52 a.m. The DON reviewed the TRUEtrack manufacturers owner's booklet and stated "I had no idea the glucometers were to be used for one person only. We had talked about that last week, and we were planning on going to individual lancet pens for the residents. I never thought to look at the owner's booklet for the glucometers we are currently using." The DON verified the TRUEtrack glucometers intended for single use was being used for multiple residents on the different units in the facility and even if they were cleaned between use, they could be a concern for the transmission of blood-borne diseases. The DON further stated she would get them removed from use right away. The DON verified staff had not followed policy for using glucometers. Eye drops: On 11/2/15, at 4:52 p.m. LPN-G was observed to stop R122 from entering the dining room. LPN-G removed R122's glasses and proceeded to place eye drops in both eyes. At no time was LPN-G observed to don gloves or wash her hands after	21390		

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21390	Continued From page 55 installing the eye drops. On 11/2/15, at 5:10 p.m. LPN-G stated she had administered artificial tears to R122. She verified she should have worn gloves while administering eye drop medications and should have washed her hands after administering the medication. The Instillation of Eye Drops policy dated 1/2014, directed the staff to utilize gloves while administering eye medication. On 11/6/15, at 8:20 a.m. RN-B stated staff were to utilize gloves and wash their hands after eye medication administration. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could monitor to assure procedures are implemented related to handwashing and glove use in order to prevent the spread of infections. The DON or designee could develop a monitoring system to ensure compliance. The QAA committee could review monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most	21426		11/30/15

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21426	Continued From page 56 current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R104, R170, R202, R224) and 1 of 5 employees (NA-J) received the tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines. Findings include: RESIDENT TST: R104 was admitted to the facility on 10/12/15. R104's electronic medical administration record (MAR) indicated R104 received the first step TST on 10/13/15, and this test was read as negative and 0 millimeters (mm) induration on 10/14/15	21426	Corrected	

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21426	Continued From page 57 (one day later). (CDC guidelines include skin test reaction should be read between 48 and 72 hours after administration.) R104's MAR indicated R104 received the second step TST 10/26/15, and this test was read as negative on 10/28/15. However, the record failed to indicate millimeters of induration and CDC guidelines include: exact number of mm of induration (if no induration, document "0" mm). R170 was admitted to the facility on 6/10/15. R170's MAR indicated R170 received the first step TST on 6/10/15, and this test was read as negative on 6/12/15. The MAR failed to indicate the millimeters of induration. R170's MAR indicated R170 received the second step TST 10/26/15, and this test was read as negative on 10/28/15. The record failed to indicate millimeters of induration. R202 was admitted to the facility on 8/31/15. R202's MAR indicated R202 received the first step TST on 9/1/15, and this test was read as negative on 9/3/15. R202's MAR indicated R202's received the second step TST 9/15/15, and this test was read as negative on 9/17/15. The record failed to indicate millimeters of induration. R224 was admitted to the facility on 10/15/15. R202's MAR indicated R202 received the first step TST on 10/16/15, and this test was read as negative on 10/17/15 (one day later instead of the recommended 48-72 hours). R224's MAR indicated R224's received the second step TST 10/29/15, and this test was read as negative on 10/31/15. The record failed to indicate millimeters of induration.	21426		

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21426	Continued From page 58 EMPLOYEE TST: Nursing assistant (NA)-K's hire date was 10/27/15. NA-K's employee file indicated TSTs were completed at another health facility. The administration form indicated NA-K received the first step of her TST on 8/7/15. This test was read on 8/10/15, with a negative - 0 mm result. NA-K received the second step TST on 8/14/15. This test was read on 8/14/15, with a negative-0mm result (read the same day it had been administered). On 11/5/15, at 11:30 the director of nursing (DON) confirmed the results of resident's TST were not documented accurately. The DON stated the staff were directed to document the millimeters of induration and if there is no induration the record needs to indicate 0 induration. On 11/5/15 at 1:40 p.m. the quality coordinator nurse verified 4 of the 5 residents reviewed had incomplete documentation, the results were noted to be negative and did not indicate the millimeters of induration. On 11/6/15, at 11:00 a.m. the DON verified NA-K's TST administration form indicated the TST had been given and read on the same day and should not have been. The facility's Tuberculosis Prevention and Control policy dated 12/12, indicated all residents would	21426		

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21426	Continued From page 59 receive a baseline TB screening within 72 hours of admission. The baseline TB screening consisted of assessing the resident ' s risk factors for TB, assessing for current symptoms of active TB disease and testing for the presence of infection by administering the two step TST. Written documentation (including the dates and results) of all pertinent TB testing and evaluations will be easily accessible in the resident's medical record. The facility policy also indicated all health care workers would be will be tested for TB prior to employment. The policy indicated baseline TB screening at the time of hire is required for all health care workers in Minnesota and consists of two components, assessing for current symptoms of active TB disease and testing of the presence of infection by administering a two-step TST. At time of reading: · Name and signature of person reading test · Date and time test read · Exact number of mm of induration (if no induration, document "0" mm) · Interpretation of reading (i.e., positive or negative, based on individual's risk factors) SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could provide education for staff regarding resident and staff tuberculosis screening and testing. The DON and/or designee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21530	Continued From page 60	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		11/30/15

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21530	Continued From page 61 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility consultant pharmacist failed to ensure sleep patterns were identified and monitored in order to determine sleep medication effectiveness and failed to ensure non pharmacological interventions had been identified and implemented prior to the use of hypnotic (for sleep) medication for 1 of 1 resident (R203) who received daily medication for sleep. Findings Include: R203's admission Minimum Data Set MDS dated 9/4/15, indicated R203 had dementia with severe cognitive impairment and required extensive staff assist for mobility, dressing and toileting. Section D0200 of the MDS did not indicate R203 had any trouble falling or staying asleep or sleeping too much. R203's care plan dated 9/17/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R203's Nursing Assistant (NA) care plan did not include any non-pharmacological interventions to promote sleep. R203's current physician's orders dated 10/12/15,	21530	Corrected	

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21530	Continued From page 62 directed staff to administer Trazodone HCL tablet 50 mg by mouth at bed time for insomnia. The consulting pharmacist November 2015, report did not address R203's usage of Trazodone or sleep. On 11/5/15, at 11:43 a.m. registered nurse (RN) verified R203 received Trazadone due to not sleeping. RN-A stated she did not complete a sleep study assessment prior the initiation of or after the medication was administered. RN-A also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R203's medical record. In addition, RN-A verified R203's care plan lacked any indication R203 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs / symptoms of adverse reactions to monitor for. RN-A confirmed the consulting pharmacist had not identified or addressed R203's Trazadone use for sleep. The policy, Consultant Pharmacist Reports/Medication Review (Monthly Report), undated, indicated the consultant pharmacist reviewed the medication regimen of each resident monthly. The consultant pharmacist's evaluation included evaluating indications for use of a medication, what monitoring was being completed for the medication and appropriateness of the medication. SUGGESTED METHOD OF CORRECTION:	21530		

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21530	Continued From page 63 The director of nursing or designee and the consulting pharmacist could establish a system to monitor residents receiving antipsychotic medications and assure adequate indications for use are identified. The quality assurance committee could review the process to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		11/30/15

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21540	Continued From page 64 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive sleep assessment and sleep monitoring was completed and failed to identify non- pharmacological interventions for sleep prior to the administration of a hypnotic (used for sleep) for 1 of 5 residents (R203) reviewed for unnecessary medications. Findings Include: R203's admission Minimum Data Set MDS dated 9/4/15, indicated R203 had dementia with severe cognitive impairment and required extensive staff assist for mobility, dressing and toileting. Section D0200 of the MDS did not indicate R203 had any trouble falling or staying asleep or sleeping too much. R203's care plan dated 9/17/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R203's Nursing Assistant (NA) care plan did not include any non-pharmacological interventions to promote sleep. R203's current physician's orders dated 10/12/15, directed staff to administer Trazodone HCL tablet 50 mg by mouth at bed time for insomnia.	21540	Corrected	

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21540	Continued From page 65 On 11/5/15, at 5:55 a.m. R203 was observed in bed, asleep. -At 6:00 a.m. NA-A and NA-B were observed to transfer R203 from bed into the wheelchair, wheel R203 to the dining room and provide R203 with a cup of coffee. -At 7:40 a.m. R203 was observed eating independently. On 11/5/15, at 11:43 a.m. registered nurse (RN) verified R203 was on Trazadone due to not sleeping. RN-A stated she did not complete a sleep study assessment prior the initiation of or after the medication was administered. RN-A also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R203's medical record. In addition, RN-A verified R203's care plan lacked any indication R203 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs / symptoms of adverse reactions to monitor for. A policy on conducting sleep studies was requested however, no policy was received. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related medication monitoring. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.	21540		

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21540	Continued From page 66 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled and dated when opened for 1 of 6 residents (R122) whose medications were observed for medication storage. In addition, the facility failed to ensure expired stock Aplisol (serum protein derivative used to test for tuberculosis infection) was discarded after being opened greater than 30 days. This had the potential to affect all new admission on 1 of 4 units (Cedar) and newly hired staff. Findings include: On 11/4/15, at 8:54 a.m. an opened multi-dose vial of Aplisol was observed in the Cedar wing medication storage room refrigerator with and "open date" of 8/21/15, handwritten on the label. Review of the JHP Pharmaceuticals, LLC (manufacturer of Aplisol) included the following guidelines for storage: "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." Licensed practical nurse (LPN)-E was present during the observation and confirmed the	21620	Corrected	11/30/15

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21620	Continued From page 67 Aplisol serum had been open greater than 30 days and should have been discarded to ensure it was not used. -At 9:04 a.m. R122's Alphagan eye drops were stored in the medication cart was observed opened, used and undated. An unlabeled bottle of lumigan eyedrops was also observed. LPN-E stated the medication belonged to R122, and confirmed the bottle lacked a pharmacy label. LPN-E reported the medication came from the eye doctor, therefore, did not have a label indicating who the medication belonged to or directions for administration. LPN-E confirmed all eyedrop medications should be dated when opened and all medications should have a pharmacy label attached. -On 11/5/15, at 6:36 a.m. the same expired Aplisol vial remained in the Cedar wing medication refrigerator. Licensed Practical Nurse (LPN)-F stated it should have been destroyed and gave the expired Aplisol to Registered Nurse (RN)-B for destruction. On 11/5/15, at 6:41 a.m. RN-B confirmed all medications should include a pharmacy label, and stated the facility should have verified the order and obtained a pharmacy label for the lumigan eye drops. RN-B stated all eyedrop medication should be dated when opened, and the Aplisol should have been disposed of when it expired, 30 days after opening the vial. On 11/5/15, at 2:29 p.m. the director of nursing (DON) indicated staff were supposed to date medication bottles when opened, including eye drops. The DON stated all medications should	21620		

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21620	Continued From page 68 have a pharmacy label attached unless it was stock medication and confirmed the Aplisol should have been disposed of. A policy regarding medication storage was requested but not provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review and revise the policies and procedures related the dating, and labeling and destruction of expired medications. The DON or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21685	Corrected	11/30/15

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review, the facility failed to ensure wheelchair armrests, resident mechanical lifts and a lap tray were maintained in a clean and sanitary condition for 1 of 2 residents (R23) who had torn, uncleanable arm rests, for 2 of 2 residents (R23, R55) in Lakes neighborhood who required the use of a mechanical lift and for 1 of 1 resident (R25) who utilized a lap tray. In addition, the facility failed to provide a clean and sanitary environment in resident rooms for 7 of 7 resident rooms (213, 215, 310, 418, 423, 426,413) which were observed to have uncleanable surfaces attached to equipment and room furnishings. Lastly, the facility failed to ensure the kitchen and kitchen food storage areas were maintained in a clean and sanitary manner.

Findings include:

R23's wheelchair armrests were torn and uncleanable and the mechanical lift had non cleanable foam padding attached to it.

R23's quarterly Minimum Data Set (MDS) dated 9/29/15, indicated R23 had cognitive impairment, was unable to ambulate and utilized a wheelchair for all destinations.

R23's care plan dated 1/7/15, indicated R23 required the use of a wheelchair for mobility to all destinations.

On 11/3/15, at 9:00 a.m. R23's wheelchair arm rests were observed torn on both sides with visible foam padding exposed.

On 11/4/15, at 7:10 a.m. nursing assistant (NA)-F

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and NA-H were observed to transfer R23 into the wheelchair via a full body EZ mechanical lift. The hydraulic portion of the lift moved the arm of the lift which held the sling / resident during the transfer. The lower portion of the hydraulic bar had a porous black foam piece wrapped around it and secured with black adhesive tape. The tape was peeling away from the foam. The center of the sling strap bar was also observed to have foam padding added to prevent the resident from hitting their head on the bar. NA-H stated the lift was utilized for R23 an R55. R23's wheelchair armrests were observed torn approximately 4-6 inches on both sides of the arm rest with the foam padding exposed. The arm rests and the mechanical lift were uncleanable.

On 11/5/15, at 6:30 a.m. NA-H stated R23's arm rests had been torn for a long time. NA-H stated R23's family had applied tape to them in the past to make them smoother, but the tape had been removed.

Review of the EZ Lift manufactures manual dated 9/2008, did not include directions or suggestions related to the addition of foam padding to the machines.

On 11/5/15, at 10:55 a.m. maintenance staff (MS)-A stated he did not know when the foam padding was added to the mechanical lift. He verified the foam padding and adhesive tape did not create a cleanable surface and was not a recommended interventions from the manufacturer. MS-A stated he would remove the padding. In addition, MS-A verified R23's arm rests were in need of repair and could easily be

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21685	Continued From page 71 replaced. He stated nursing staff should have sent a work request to the maintenance director so the repair could have been completed. MS-A stated he would replace the arm rests. R25's wheelchair lap tray was not maintained in a clean and sanitary manner. R25's quarterly MDS dated 0/11/15, indicated R25 was cognitively impaired, required extensive assist with positioning, transfers and eating and a restraint to prevent R25 from rising from the chair was in place. R25's care plan dated 9/14/15, indicated R25 was to have wheelchair tray on at all times while in wheelchair and staff were directed to anticipate his needs. On 11/4/15, at 7:52 a.m. R25 was observed seated in the wheelchair, in the Woods dining with NA-K assisting him with the breakfast meal. The lap tray is observed in use. The tray was observed to have a three inch black porous foam piece taped on with two inch clear tape, along the 20 inch edge of the tray next to R25's abdomen. -At 8:54 a.m. NA-K assisted R25 to his room. NA-K verified food debris was on the tray and also on the black foam. NA-K wiped the tray off. NA-K stated the edge of the tray was sharp so the foam was applied for cushion so when R25 leaned forward the edge of the tray did press against his stomach. NA-K also stated she did not now how often the foam was changed or if it was cleaned any other way than wiping it off. NA-K also stated she did not know how long it had been on and she just wiped it off when it was dirty.	21685		

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21685	Continued From page 72 On 11/06/2015, at 1:53 p.m. R25 was observed in his wheelchair, asleep. R25's lap tray has food debris on the tray and on the black foam and adhesive tape. At this time, RN-B verified tray was dirty and the foam was an uncleanable surface. RN-B stated R25 needed the lap tray and staff were coming up with a plan to change the tray out and replace it with one that was safe and cleanable. On 11/6/15, at 2:10 p.m. the director of nursing (DON) verified R25's tray was needed, however, the tray with the black porous foam adhered was not a cleanable and sanitary surface. The DON stated staff were working towards removing the foam that was attached to the equipment and replace it with an acceptable option. The DON stated the facility did not have a policy related to the use of the foam padding or for cleaning it. ENVIRONMENT: On 11/6/15, from 10:45 am until 11:27 a.m. a tour of the facility was completed with the director of maintenance (DOM) and the DOM verified the following concerns: -Room 426's upper bilateral bed rails had three inch black porous foam attached to the rails and taped on with two inch black tape which was raveling and had dried debris on it. The bathroom was observed to have a half inch by 14 inch long by 10 inch wide black porous foam tape was taped to the pipe on the back of the toilet, behind the toilet seat. -Room 423's upper bilateral side rails had three	21685		

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21685	Continued From page 73 inch black porous foam attached and taped with two inch black tape which was raveling. The bathroom toilet was observed to have half inch by 14 inch long by 10 inch wide sheet of black porous foam taped to the pipe on the back of the toilet, behind the toilet seat. -Room 213's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape which was raveling and had dried debris on it. -Room 413's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape. -Room 215's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape which was raveling and hanging down. The tape has dried debris on it. -Room 310's bathroom door frame had two inch black tape and two inch duct tape covering an 18 inch section over the door latch, frame section. The grab bar attached to wall next to the toilet had 24 inch by three inch black porous foam attached and secured with black tape. The tape was raveling and had debris on it. The DOM verified the maintenance staff applied the foam to all of the identified areas and the facility did not have a cleaning policy for the foam. The DOM stated he did not think anyone removed and cleaned the backsides or under the foam. The DOM stated the facility did not have a schedule for changing the foam. The DOM stated the facility had never thought of the safety part of infection risks or the cleaning process. The DOM verified the foam was not cleanable and stated staff had already started to remove the foam.	21685		

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	00298	A. BUILDING: _____ B. WING _____	11/06/2015

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21685	Continued From page 74 KITCHEN: On 11/4/15, at 12:48 p.m. a tour of the kitchen was completed with the dietary manager (DM) and the following was observed: -The outer eight inch perimeter of the entire kitchen floor area was observed to have food debris and a black/gray debris build up on it. The food/black/gray debris was also observed behind the stove, under the food preparation counters and alongside and behind the food steam machine. In addition, the dry food storage area was observed to have food particles and black gray debris build up around the outer eight inch perimeter of the floor. The debris was also observed under the wire food storage shelving. The DM verified the floors were not clean and sanitary and stated staff were assigned cleaning and deep cleaning duties. The DM stated the floors were not clean and staff were not cleaning the entire flooring as directed to do so. The facility policy, "Cleaning Schedule" dated 03/05, indicated regular cleaning was scheduled daily, weekly and monthly to ensure that all of the food service area was washed and sanitized. The policy indicated daily tasks included cleaning the floors, sweep and mop including the dry storage area and under all counters, fridges, cabinets and carts. SUGGESTED METHOD OF CORRECTION:	21685		

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21685	Continued From page 75 The director of nursing or designee could review and revise policy and procedures related to equipment maintenance, reporting procedures and cleaning procedures / surfaces. The director of nursing or designee could provide staff education and develop a monitoring system to ensure ongoing compliance. The Dietary Manager (DM) or designee could develop, review and/or revise policies and procedures to ensure a sanitary environment in the kitchen. The DM or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency and thoroughly investigate incidences of	21995	Corrected	11/30/15

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21995	Continued From page 76 possible mistreatment related potential sexual misconduct for 1 of 3 incident reports reviewed and for 1 of 2 residents (R148, R145) who were involved with potential sexual misconduct. Findings include: R148's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R148 was diagnosed with dementia, anxiety disorder, depression and seizure disorder. The MDS also indicated R148 had severe cognitive impairment, required extensive assist for activities of daily living and supervision - limited assistance of one staff while ambulating. The MDS also indicated R148 displayed physical aggression towards other 1-3 days and wandering behaviors 4-6 days during the MDS assessment period. R148's The Activities of Daily Living Care Area Assessment (CAA) dated 12/29/14, indicated R148 was able to ambulate independently without any type of assistive device and she was at risk for falls. R148's Cognition CAA dated 12/29/15, indicated R148 was diagnosed with dementia and was at risk for further cognitive decline due to disease progression. R148 had difficulty communication wants/needs to others and the staff were to anticipate her needs. R148's care plan dated 12/26/14, indicated R148 was at risk for falls, wandered throughout the nursing unit and was unable to remove herself	21995		

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21995	Continued From page 77	21995		

from harm. The care plan directed staff to intervene and separate resident as safety concerns were identified, to ensure R148 was not alone with R145 and to keep the environment safe.

R145's quarterly MDS dated 8/6/15, indicated R145 was diagnosed with chronic obstructive pulmonary disease and had moderate cognitive impairment. The MDS indicated R145 required extensive assistance with activities of daily living and had not displayed dementia or mood/behavior indicators.

R145's care plan dated 3/31/15, identified a concern related to R145 attempting to have intimacy / courtship behaviors directed towards female residents residing in the community. The goal was to prevent courtship behaviors with the unidentified female resident as it was "nonconsensual."

Review of R148's Progress Notes revealed the following:

-On 3/17/15, at 3:45 p.m. R148 was found in the Rivers Community seated next to R145 (a male resident with dementia). R145 had his hand down R148's pants. The staff members separated the residents and directed the staff to continue to monitor R148's whereabouts and intervene as necessary. The facility did not complete an incident report, complete a thorough investigation nor reported it to the State Agency, as required.

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21995	Continued From page 78 On 11/4/15, at 12:00 p.m. family member (FM)-A stated R148 had increased wandering in the past year. She stated she was aware R148 entered other resident rooms and often picked up items that did not belong to her. She stated the facility staff kept an eye on R148 as best as possible. FM-A did not express any concerns related to inappropriate sexual touch. On 11/4/15, at 12:48 p.m. licensed practical nurse (LPN)-I stated R148 wandered around the Lakes Neighborhood and at times would have altercations with other residents. She stated when that happened, the residents were separated. LPN-I stated if she had noticed concerns with the residents, the residents would be separated. She stated she was aware of R148 being involved with resident to resident altercations, but had not observed any of the alleged incidences. On 11/4/15, at 1:02 p.m. activity aide (AA)-A stated R148 continuously wandered and paced on the unit. AA-A stated she did not feel R148 disrupted other residents and when she noticed R148 wandering, she tried to engage R148 in a one to one activity. On 11/4/15, at 1:22 p.m. nursing assistant (NA)-H stated R148 wandered daily. She stated R148 did not seem to be afraid of any of the other residents nor did the other residents seem to be afraid of R148. She stated she separated the residents if she saw a concern. On 11/4/15, at 1:40 p.m. licensed social worker	21995		

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21995	Continued From page 79 (LSW)-A stated she had not been made aware of any concerns related to resident to resident concerns on the Lakes Neighborhood. Therefore, was unaware of any investigations that may have taken place. On 11/5/15, at 12:06 p.m. registered nurse (RN)-A stated the altercations involving R148 occurred with other residents with dementia therefore, the residents were just to be observed and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed because R148 had not attempted to open the doors which decreased the behaviors with some of the male residents (R145). RN-A stated the facility had not put any other interventions in place to increase the supervision on the Lakes Neighborhood. On 11/5/16, at 12:14 p.m. LSW-A stated the facility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations and ensure resident safety. LSW-A stated the only new intervention implemented was to close the doors between the two dementia units. On 11/5/15, at 12:17 p.m. the director of nursing (DON) stated the facility had provided staff members education regarding approaching residents with dementia. She stated the activity staff and the kitchen staff had also received training so they could assist with the residents as needed. The undated Abuse Prevention Plan directed staff	21995		

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21995	Continued From page 80 to immediately report all suspected maltreatment / mistreatment to the State Agency. The plan indicated resident to resident altercations would be reportable if the residents acted "willfully." On 11/5/15, at 2:05 p.m. LSW-A stated the facility was to report any concerns related to resident to resident potential sexual misconduct if the residents were seeking each other out. LSW-A stated R148 and R145 had sought each other out as they were not involved with sexual misconduct with any other residents. LSW-A verified the incident as noted above should have been investigation and reported to the State Agency as directed by the policy. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the reporting/investigating process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21995		