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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 43LY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00598

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245366**
2.STATE VENDOR OR MEDICAID NO.
(L2) **175040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHRIS JENSEN HEALTH & REHABILITATION CENTER**
(L4) **2501 RICE LAKE ROAD**
(L5) **DULUTH, MN** (L6) **55811**

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) **11/01/2009**

6. DATE OF SURVEY **05/12/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **170** (L18)
13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NIEE 5/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/29/2016 (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
08/01/1986
(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
03/24/2016
(L33)

DETERMINATION APPROVAL

CCN: 24 5366

On May 12, 2016, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 7, 2016. We presumed, based on your plan of correction that the facility had corrected these deficiencies as of April 19, 2016. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on April 7, 2016, as of April 19, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 19, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016, be discontinued April 19, 2016
- Per day civil money penalty which began February 3, 2016 through February 4, 2016, remain in effect
- Per day civil money penalty which began February 5, 2016, be discontinued, as of April 19, 2016

In our letter of April 14, 2016, this Department recommended an additional enforcement remedy as a result of the April 7, 2016 revisit findings. Since the facility achieved compliance and the CMS Region V Office had not notified the facility of their decision of the additional remedy imposition.

The Department is changing its decision and recommending the following action to the CMS Region V Office:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016, be rescinded.

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

As the facility was notified in our letter of February 29, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

Refer to the CMS 2567b for the results of the May 12, 2016 visit.

Effective April 19, 2016, the facility is certified for 170 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245366

May 17, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

Dear Ms. Porter:

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 April 19, 2016 the above facility is certified for:

170 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 170 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
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
May 17, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366026

Dear Ms. Porter:

On February 29, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 5, 2016. (42 CFR 488.422)

On March 7, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016
- Per day civil money penalty of $5,500.00 per day for the two (2) days, beginning February 3, 2016 and continuing through February 4, 2016, for a total of $11,000.00
- Per day civil money penalty of $350.00 per day beginning February 5, 2016.

Also, the CMS Region V Office notified you in their letter of March 7, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on February 10, 2016 that included an investigation of complaint number H5366066. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On April 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 29, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on February 10, 2016.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, we recommended the following action to the CMS Region V Office related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016, remain in effect
- Per day civil money penalty which began February 3, 2016 through February 4, 2016, remain in effect
- Per day civil money penalty which began February 5, 2016, remain in effect

Furthermore, based on finding the facility had not achieved substantial compliance at the April 7, 2016 PCR, we recommended the following additional enforcement remedy to the CMS Region V Office for imposition:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016.

On May 12, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 19, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 7, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 19, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016, be discontinued April 19, 2016

- Per day civil money penalty which began February 3, 2016 through February 4, 2016, remain in effect

- Per day civil money penalty which began February 5, 2016, be discontinued, as of April 19, 2016

In our letter of April 14, 2016, this Department recommended an additional enforcement remedy as a result of the April 7, 2016 revisit findings. Since the facility achieved compliance and the CMS Region V Office had not notified you of their decision of the additional remedy imposition. The Department is changing its decision and recommending the following action to the CMS Region V Office:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016, be rescinded.

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

As we notified you in our letter of February 29, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245366	A. Building B. Wing	5/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 04/19/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 04/19/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	05/17/2016	18619	05/12/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/10/2016

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

Electronically delivered
May 17, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366026

Dear Ms. Porter:

On February 29, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 5, 2016. (42 CFR 488.422)

On March 7, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016
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- Per day civil money penalty of $350.00 per day beginning February 5, 2016.

Also, the CMS Region V Office notified you in their letter of March 7, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on February 10, 2016 that included an investigation of complaint number H5366066. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On April 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 29, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on February 10, 2016.
As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would

remain in effect.

In addition, we recommended the following action to the CMS Region V Office related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016, remain in effect
- Per day civil money penalty which began February 3, 2016 through February 4, 2016, remain in effect
- Per day civil money penalty which began February 5, 2016, remain in effect

Furthermore, based on finding the facility had not achieved substantial compliance at the April 7, 2016 PCR, we recommended the following additional enforcement remedy to the CMS Region V Office for imposition:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016.

On May 12, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 19, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 7, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 19, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions, effective April 10, 2016, be discontinued April 19, 2016

- Per day civil money penalty which began February 3, 2016 through February 4, 2016, remain in effect

- Per day civil money penalty which began February 5, 2016, be discontinued, as of April 19, 2016

In our letter of April 14, 2016, this Department recommended an additional enforcement remedy as a result of the April 7, 2016 revisit findings. Since the facility achieved compliance and the CMS Region V Office had not notified you of their decision of the additional remedy imposition. The Department is changing its decision and recommending the following action to the CMS Region V Office:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016, be rescinded.

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

As we notified you in our letter of February 29, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00598		5/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 05/12/2016	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 05/12/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	05/17/2016	18619	05/12/201
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/10/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 43LY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00598

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245366**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHRIS JENSEN HEALTH & REHABILITATION CENTER**
(L4) **2501 RICE LAKE ROAD**
(L5) **DULUTH, MN** (L6) **55811**

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) **11/01/2009**

6. DATE OF SURVEY **04/07/2016** (L34)
(L10)

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

8. ACCREDITATION STATUS:
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

12.Total Facility Beds **170** (L18)

13.Total Certified Beds **170** (L17)

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
	170			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NEII 05/27/2015
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/27/2016
(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
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

==========

CCN: 24 5366

On April 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 5, 2016, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 10, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of March 29, 2016. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on February 10, 2016. The deficiencies not corrected are as follows:

- **F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan**
- **F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores**

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of state monitoring remained in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions effective April 10, 2016, remain in effect. (42 CFR 488.418 (a))
- Per day civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Per day civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016. (42 CFR 488.430 through 488.444)

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

Refer to the CMS 2567b and CMS 2567 along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366026, H5366066

Dear Ms. Porter:

On February 29, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 5, 2016. (42 CFR 488.422)

On March 7, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for all Medicare and Medicaid admissions effective April 10, 2016. (42 CFR 488.418 (a))
- Federal Civil Money Penalty of $5,500.00 per day for the two (2) days beginning February 3, 2016 and continuing through February 4, 2016 for a total of $11,000.00
- Federal Civil Money Penalty of $350.00 per day beginning February 5, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on February 10, 2016 that included an investigation of complaint number H5366066. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On April 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 5, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 29, 2016. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on February 10, 2016. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 7, 2016:

- Discretionary denial of payment for all Medicare and Medicaid admissions effective April 10, 2016, remain in effect. (42 CFR 488.418 (a))
- Per day civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Per day civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

- Per day civil money penalty be increased for deficiency cited at F314 (S/S=G), effective April 7, 2016. (42 CFR 488.430 through 488.444)

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

As we notified you in our letter of February 29, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2016.

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

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

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
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

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,

- Include electronic acknowledgement signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 August 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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
	245366	A. BUILDING _____ B. WING _____	R 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on April 5, 6, 7, 2016, to determine compliance with Federal deficiencies issued during a recertification survey, which included investigating complaint number H5366066 (substantiated at F323), exited on February 10, 2016. During this visit the following regulations were determined to be not corrected. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide offloading services as directed by the care plan for 1 of 3 residents (R183) who required elevation of heels	{F 282}	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also	4/19/16

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

Electronically Signed | 4/15/2016

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{F 282}	Continued From page 1 off bed with pillows and was observed to not receive the assistance. Findings include: R183's care plan revised on 3/19/16, indicated R183 was at high risk for pressure ulcers / skin issues related to impaired mobility, dementia, weakness and incontinence. The plan indicated on 2/17/16, R183 had a stage two blister to the left heel which was identified on admission. An entry dated 1/20/16, indicated R183 had acquired a sacral (tail bone) ulcer which was unable to be staged. The plan directed staff to assist R183 with turn/reposition at least every two hours or more often as needed or requested, elevate heels off bed with pillows at all times, provide ROHO cushion to wheelchair, alternating pressure mattress to bed, heel protectors on at all times and to lay down after each meal. The plan indicated on 3/23/16, the alternating pressure mattress was discontinued and a Panaca with scoop mattress was initiated as a fall prevention. R183's nursing assistant care guide dated 4/6/16, directed staff to assist R183 with bed mobility and to reposition every two hours, transfer with SABINA (mechanical lift) , have heel protectors on at all times, elevate heels off the bed with pillows, had a pressure relieving mattress and pressure reducing cushion in the wheelchair. On 4/5/16, at 1:33 p.m. R183 was observed in the dining room, seated in a wheelchair, being assisted to eat lunch. R183 was observed to have bilateral white sheepskin heel protectors on	{F 282}	not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Resident #183 care plan of care was re-evaluated and determined he would use a pressure relieving boot (Prevelon) for complete pressure relief . All residents who have been care planned for offloading services for heels were identified and interventions were reassessed and appropriate interventions were placed. Education and return demonstration was provided to nursing staff on offloading and positioning interventions to promote the healing of pressure ulcers. Proper use of offloading devices will be audited every shift for 6 weeks and these results will be reviewed through the QA	

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{F 282}	Continued From page 2 both feet and a ROHO cushion in the wheelchair. -At 1:54 p.m. R183 was observed to be laying in bed, sleeping. Feet were covered with blankets. -At 2:37 p.m. staff was observed to exit R183's room. R183 was observed in bed, lying on the right side. Feet were covered with blankets. -At approximately 3:20 p.m. R183 remained in bed. Feet were uncovered and observed to be lying flat on the bed. Sheepskin protectors on. -At 3:30 p.m. R183 remained in bed. Feet remained positioned flat on the bed, not elevated/offloaded on pillows as directed by the care plan. -At 3:37 p.m. registered nurse (RN)-B was asked to evaluate R183's positioning. RN-B verified R183's heels were directly on the bed with no pillow/s under his feet for elevation. RN-B placed a pillow under R183's feet however, positioned R183's feet/heels directly on top of the pillow. RN-B stated R183's feet needed to be elevated / offloaded because of the wound to his heel. On 4/6/16, at 10:25 a.m. nursing assistant (NA)-B was observed to wheel R183 to his room. NA-C and NA-B assisted R183 into bed via the mechanical lift. The NA's were asked about R183's wounds and if there were dressings on the heels. R183's heel protectors were removed and a dressing on the left side of the left heel was observed. The protectors were put back on R183's feet, however, R183's heels were placed directly on top of a pillow instead in a floating/elevated position in order to avoid any pressure on the heels. -At 11:10 a.m. R183 remained in the same position with bilateral heels resting on top of the pillow. -At 11:27 a.m. RN-B confirmed R183's heels	{F 282}	process.	

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{F 282}	Continued From page 3 were positioned directly on the pillow and were not floated correctly. At this same time, RN-C entered R183's room and stated R183 had regular fuzzy protective heel protectors on and maybe they should get Prevelone (pressure relieving heel boots) boots for R183. RN-B stated then maybe they could discontinue the intervention of floating the heels. -At 11:29 a.m. RN-A stated R183's pillow was not placed under R183's feet where it should be. RN-A verified R183's left foot was resting on top of the pillow and not floated as directed and stated perhaps R183 needed new heel protectors. At this time, RN-C brought in a different pair of protective boots. On 4/6/16, at 8:59 a.m. the director of nursing (DON) stated she had been informed by other staff members about the observation of R183 in bed without heels being elevated off the bed therefore she had visited with NA-A and provided NA-A individual education regarding the care planned intervention of floating the heels. The DON stated the facility was very serious about implementing interventions as ordered and following the plan of care. The DON stated the morning of the observation, extra training about following the care plan was provided to all staff members. On 4/7/16, at approximately 10:00 a.m. the DON confirmed R183's heels being placed directly on a pillow did not constitute pressure relief/floating of the heels off the bed, as directed by the care plan.	{F 282}		

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{F 282}	Continued From page 4 A policy for following the plan of care was not obtained.	{F 282}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess and/or modify individualized interventions following the identification of an increase in the size of a sacral pressure ulcer and failed to implement offloading interventions in order to promote the healing of a heel pressure ulcer as directed by the care plan for 1 of 3 residents (R183) reviewed who had two stage three pressure related ulcers. The failure to re-assess the sacral wound upon identification of the increase in size resulted in actual harm to R183. Findings include: R183's quarterly Minimum Data Set (MDS) dated 3/16/16, indicated R183's diagnoses included dementia, anemia, muscle weakness and chronic obstructive pulmonary disease. The MDS indicated R183 had severe cognitive impairment	{F 314}	Resident #183 was re-assessed for Braden and tissue tolerance and an individual plan of care was developed to promote healing of current pressure ulcers. Care plan reflects new interventions such as: 1 hour repositioning, side to side only while in bed, Prevelon boots on at all times and D/C'd pillow to off load while in bed. MD has written new treatment orders. All resident were assessed with Braden and tissue tolerance assessments and individual plans of care were reviewed and updated to ensure proper care and services to prevent development of pressure ulcers. The systematic change is the use of a	4/19/16

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{F 314}	Continued From page 5 and required extensive assistance of two staff with bed mobility and toileting, extensive assist of one staff for transferring and personal hygiene, and did not walk. In addition, the MDS indicated R183 had one stage two (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed without slough) pressure ulcer and one unstageable pressure ulcer (surface is covered with yellow, brown, black or dead tissue. It is not possible to see how deep the wound is). R183's Braden Scale For Predicting Pressure Sore Risk (tool used to predict risk for pressure ulcers) dated 12/23/15, indicated R183 was not at risk for pressure related ulcers. R183's Pressure Ulcer Care Area Assessment (CAA) dated 12/28/15, indicated R183 was at risk for the development of a pressure ulcer/skin issues due to dementia and on 12/24/15, was noted to have a fluid filled blister. The CAA also indicated R183 was dependent on staff to meet his needs, was frequently incontinent of bladder, always incontinent of bowel, needed reminders to offload (relieving the pressure to an area) and reposition, was to wear blue boots while in bed and utilized a pressure relieving cushion in the wheelchair and bed. In addition, the CAA indicated the wound care nurse would assess R183's wound weekly. R183's Nutrition Status CAA dated 12/29/15, indicated R183 was found to have a left outer heel blister and nursing was to apply soft pillow boots to prevent further blisters. R183's Skin-Admission Skin Examination/Evaluation form dated 2/13/16, which was completed following a return from the hospital, indicated R183 had the following skin	{F 314}	New Wound Occurrence/Change in Wound form which has been implemented as a checklist to ensure a systematic approach is taken to wound care. This form assures that all facets of wound care have been addressed if there is a new wound or change in current wound. Education was provided to nursing staff on reassessment and modifications needed when a pressure ulcer shows signs of deterioration. Education and return demonstration was provided to nursing staff on offloading and positioning interventions to promote the healing of pressure ulcers. Reassessment and modifications when a pressure ulcer shows signs of deterioration will be audited twice per week for 3 months and results will be brought through the QA process. Proper use of offloading devices will be audited every shift for 6 weeks and these results will be reviewed through the QA process.	

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{F 314}	Continued From page 6 issues: -Coccyx area 1.5 centimeters (cm) by 1.0 cm open area -Right side of heel open area measured 1.5 inch by 1 inch. -Left heel having 1.0 x 1.0 inch not open area, but thin. -"mushy heels" to bilateral heels. R183's Tissue Tolerance for bed form (used to determine the skin's ability to withstand pressure without change) dated 2/15/16, indicated the assessment was to be completed upon admission, annually and with significant change in status, upon emergence of a pressure ulcer, and with changes in pressure surfaces. The form indicated R183 was not independent with bed mobility and directed the assessor to follow the algorithm in order to determine positioning needs. The form directed the assessor to inspect R183's skin after remaining in the same position for two hours. At the two hour interval, R183's skin was assessed to be red and non-blanchable and directed the assessor to re-exam the skin after one hour of continuous pressure. At the one hour interval, R183's skin was assessed to no longer be reddened and directed the assessor to consider care planning for R183 to be repositioned every two hours when in bed. The bottom of the form read: Determination of positioning schedule should be done in conjunction with the Comprehensive Skin Risk Collection Tool, the Braden and resident's preferences and included in the analysis. (completed two days after return form hospital). R183's physician's orders included a wound care dressing treatment to the sacral area and left heel dated 3/14/16. The order directed staff to cleanse	{F 314}		

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{F 314}	Continued From page 7 area with normal saline and pat dry, cut Silver Calcium Alginate to fit inside wound, cover with foam dressing, change every morning and as needed. R183's Braden Scale dated 3/16/16, indicated R183 was at risk for the development of pressure related ulcers. R183's care plan revised on 1/15/16, indicated R183 did not walk, required two staff assistance for bed mobility, one staff for transfers with mechanical lift, and directed staff to observe skin with all cares and report any changes noted to nursing. A care plan problem revised on 3/19/16, indicated R183 was at high risk for pressure ulcers/skin issues related to impaired mobility, dementia, weakness, incontinence, pain, weakness, lung disease and anxiety/depression. The plan indicated on 12/17/15, R183 had a stage two blister to left heel on admit. The plan also read: 1/20/16, Unable to stage sacrum pressure ulcer acquired. The plan directed staff to assist R183 to turn/reposition at least every two hours or more often as needed or requested, elevate heels off bed with pillows at all times, provide ROHO cushion to wheelchair, alternating pressure mattress to bed, heel protectors on at all times and to lay down after each meal. The care plan included a handwritten note dated 3/23/16, which indicated the alternative pressure mattress was discontinued and a Panaca (foam) scoop mattress was initiated as a fall prevention. R183's Tissue Tolerance for bed dated 3/26/16, indicated R183 was not independent with bed mobility. At the initial two hour interval skin check, R183's skin was found be red and non-blanchable and directed the assessor to	{F 314}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD DULUTH, MN 55811**

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{F 314}	Continued From page 8	{F 314}		

re-exam the skin after one hour of continuous pressure. At the one hour interval, R183's skin was assessed to remain red. The assessor was directed to recheck R183's skin in 30 minutes and if no longer reddened then consider care planning R183 to be repositioned every one to two hours when in bed. The bottom of the form read: Determination of positioning schedule should be done in conjunction with the Comprehensive Skin Risk Collection Tool, the Braden and resident's preferences and included in the analysis. However, this assessment was completed 10 days after the 3/16/16, Braden assessment was completed, no indication a Skin Risk Collection Tool was completed nor inclusion of R183's preferences.

R183's physician's orders also included a treatment order from the wound nurse dated 4/4/16, which directed staff to cleanse the wounds per facility protocol, pat dry, apply skin barrier paste to wound margins, apply Calcium Alginate Silver to wound bed, cover with foam dressing, and change daily.

R183's nursing assistant (NA) care guide dated 4/6/16, indicated R183 required one to two staff assistance for bed mobility, transfer with a mechanical lift, did not walk and directed staff to turn and reposition every two hours and R183 was to utilize heel protectors with heels elevated off the bed with pillows and to wear blue boots at all times.

On 4/5/16, at 1:33 p.m. R183 was observed seated in a wheelchair, in the dining room being assisted with lunch. R183 was observed to have bilateral white, sheepskin heel protectors on both

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{F 314}	Continued From page 9 feet and a R0H0 cushion in the wheelchair. -At 1:54 p.m. R183 was observed lying in bed, on the left side. Feet were covered with blankets. -At 2:37 p.m. a NA was observed exiting R183's room. At this time, R183 was observed in bed, laying on the right side. Feet were covered with blankets. -At approximately 3:20 p.m. R183 remained in bed. Heels were observed by the surveyor to be lying flat on the mattress without pressure relief. Sheepskin protectors were on. -At 3:30 p.m. R183 remained in bed, in the same position. Feet flat on the bed not elevated/offloaded on pillows as directed by the care plan. At this time, NA-A was asked how the staff monitored to make sure all residents were repositioned in a timely manner. NA-A removed the NA care assignment sheet out of a pocket and explained how they documented when residents received care. The sheet indicated R183 was to be repositioned every two hours, have heel protectors on and heels were to be elevated off the bed on pillows. -At 3:37 p.m. registered nurse (RN)-B was asked by the surveyor to evaluate R183's positioning. RN-B verified R183's heels were lying directly on the mattress without pillows under the feet in order to elevate/offload as directed by the care plan. RN-B stated she had completed R183's dressing change earlier and also measured the wounds and thought the wounds were bigger. RN-B took an uncovered blue pillow off a chair, lifted R183's feet and positioned R183's feet directly on top of the pillow without	{F 314}		

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{F 314}	Continued From page 10	{F 314}		

offloading/elevating the heels. RN-B was not observed to float/elevate R183's heels so they were not touching a surface.
Following the observed positioning, RN-B stated R183's feet needed to be elevated/offloaded due to the wound on his heel.

On 4/6/16, at 8:38 a.m. R138 was observed to be wheeled out of his room and to the dining room for breakfast. Bilateral sheepskin heel protectors were on. R183 remained in the dining room until 10:25 a.m.

-At 10:25 a.m. NA-B wheeled R183 to his room. NA-B and NA-C were observed to transfer R183 into bed via a mechanical left. When in a standing position, NA-A removed R183's incontinent brief which revealed a dressing covering the sacral area. After a clean brief was applied R183 was assisted to bed, positioned on his back. The NAs were asked about R183's wounds and if there were dressings on the heels. The NAs removed R183's heel protectors which revealed a dressing on the left side of the left heel. The heel protectors were put back on and R183's feet were placed directly on top of a pillow instead of in a floating/elevated position in order to avoid pressure on the heels.

-At 11:27 a.m. R183 remained in the same position, on his back, with both heels resting on top of the pillow. RN-B confirmed R183's heels were directly on the pillow and were not floated/elevated correctly. RN-C entered the room and stated R183 had regular heel protectors on and maybe they should get Prevelon (pressure relieving heel protector) boots for him that would keep the pressure off the heels. RN-B stated then

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{F 314}	Continued From page 11 maybe they could discontinue the intervention of floating the heels. -At 11:29 a.m. R183 remained in the same position, feet not floated/elevated. RN-A was observed to complete dressing changes to R183's left heel pressure ulcer. RN-B assisted with R183's positioning during the treatment. RN-A asked R183 to straighten his legs and he did not. RN-A stated R183 could not straighten his legs. The dressing to the left heel was removed with no obvious drainage noted. The heel ulcer was not measured. RN-B stated the wounds were measured once a week and were just measured the day before. The treatment and dressing change was completed to the left heel as ordered. -At approximately 11:45 a.m. RN-B removed R183's right heel protector. The heel was observed red but with no open areas. RN-B stated the heel was intact and blanchable. RN-B applied Prevelon boots that were brought in by RN-C. RN-A and RN-B repositioned R183 to his right side and RN-A completed a dressing change to the sacral area. There was a small amount of drainage noted to the old dressing and the wound appeared bright red and the skin around the wound was inflamed. The area was cleansed with normal saline, patted dry, Calcium Alginate silver dressing was applied inside the wound and the wound was covered with a foam dressing. R183's wound assessment flow sheets revealed the following on each pressure ulcer: Sacral pressure ulcer was acquired at the facility with an onset date of 1/20/16. The ulcer was initially identified as unstageable. The	{F 314}		

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{F 314}	Continued From page 12 measurements of the sacral pressure ulcer were documented as: -2/16/16, 1.5 cm length x 1.5 cm width x depth which was blank. -2/21/16, 1.5 cm x 1.5 cm width x depth which was blank. -3/7/16, 1.2 cm length x 0.8 cm width x depth which was blank. -3/14/16, 1.1 cm length x 0.5 cm width x depth which was blank. -3/21/16, 0.7 cm length x 0.6 cm width x depth which was blank. -3/31/16, 0.7 cm length x 0.6 cm width x depth which was blank. -4/5/16, 2.0 cm length (an increase in 1.3 cm from last measurement and an increase in 0.5 cm from when acquired x 1.5 cm width (an increase in 0.9 cm since last measurement) and depth measurement was blank. -A hand written progress note on the Wound Assessment Flow Sheet dated 3/7/16, skin surrounding wound blanchable (redness goes aware when pressed on), pink, no drainage noted, current treatment appears to be effective, measures 1.2 x 0.8 cm. macerated appearance surrounding top of ulcer, slough (dead tissue that may have a yellow or white appearance), no odor noted, dressing intact, clean, dry. -A hand written progress note dated 3/14/16, indicated wound measurement 1.1 x 0.5 cm. 100% slough noted to wound bed, minimum amount of drainage. Treatment changed to cleanse with normal saline, pat dry, Silver Calcium Alginate to wound bed than cover with foam dressing. -A hand written progress note dated 3/21/17,	{F 314}		

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{F 314}	Continued From page 13 indicated wound measurement 0.7 x 0.6 cm. 80% slough noted to wound bed with 20% granulation. Minimum amount of brown drainage noted to gauze. No odor noted, surrounding skin pink in color. -A hand written progress note dated 3/31/16, indicated wound size, 0.7 x 0.6 cm. 80% slough, 20 % granulation, minimum amount of drainage, brown and sanguineous (containing blood) drainage. Complained of pain, treatment changed per wound nurse. -A hand written progress note dated 4/5/16, indicated wound size 2.0 x 1.5 cm. 50% of granulation noted to wound bed with 50% slough, Surrounding skin blanchable and erythematous (redness of the skin), minimum amount of serous drainage, complained of pain, PRN pain medication given, MD (medical doctor) updated regularly in change of wound size. R183's medical record lacked documentation of the wound reassessment or MD or nurse practitioner (NP) notification of the increase in wound size. R183's care plan was not modified/revised to identify the change in wound size or any change in or new interventions. R183's left heel pressure ulcer was identified as stage three (wound with full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, muscle are not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining or tunneling) and had been acquired at the facility on 12/24/15. The measurements of the left heel pressure ulcer were documented as follows:	{F 314}		

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{F 314}	Continued From page 14 -3/7/16, 2.5 cm length x 1.5 cm width x ___ depth, was blank. -3/14/16, 2.7 cm length x 1.7 cm width x ___ depth, was blank -3/21/16, 2.0 cm length x 1.1 cm width x ___ depth, was blank -3/31/16, 2.0 cm length x 1.0 cm width x ___ depth, was blank -4/5/16, 0.9 cm length x 1.7 cm width x ___ depth, was blank -A hand written progress note on the Wound Assessment Flow Sheet dated 3/7/16, indicated wound measurements were 2.5 x 1.5 cm, skin surrounding wound blanchable, pink, no drainage noted, current treatment appears to be effective macerated appearance surrounding top of ulcer, 50% slough, 50% granulation no odor. -A hand written progress note dated 3/14/16, indicated wound measurements were 2.6 x 1.7 cm, minimum amount of serous drainage, complained of moderate pain, treatment changed to cleanse with normal saline, pat dry, Silver Calcium Alginate to wound bed than cover with foam dressing. -A hand written progress note dated 3/21/16, indicated wound measurements were 2.0 x 1.1 cm. moderate amount of brown drainage, pungent odor, wound edges macerated, denied pain. -A hand written progress noted dated 3/31/16, indicated wound measured 2 cm x 1 cm. 70% slough and 30% granulation, moderate amount of sanguineous brown drainage, macerated wound edge, complained of pain, spoke with wound nurse with no change in treatment.	{F 314}		

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{F 314}	Continued From page 15 -A hand written note dated 4/5/16, indicated wound measured 0.9 x 1.7 cm, 50 % granulation and 50% slough. No odor noted, moderate amount of serous/greenish drainage, complained of pain, updated MD regularly in change of wound size. On 4/6/16 at 8:59 a.m. the director of nursing (DON) stated she had been informed by other staff members about the observation of R183 in bed without heels being elevated off the mattress so had visited with NA-A and provided more individual education. The DON stated how serious the facility was about completing interventions as ordered. The DON stated NA-A felt bad about missing the intervention but she was a newer staff member. The DON added at that time extra training about following the plan of care was completed for nursing staff members that morning before their shifts started. During the survey on 4/6/16, R183's care plan was revised to discontinue the heel protectors and the elevation of the heels off the bed with pillows at all times and Prevalon (pressure relieving heel) boots on at all times was added to the plan. The plan had an undated handwritten entry, "Prevalon boots on @ all times " and there was a line through Elevated heels off bed with pillow at all times and heel protectors on at all times. On 4/7/16, at 9:26 a.m. the DON confirmed according to the wound measurements, the wound to R183's sacrum had increased in size and R183's medical record indicated there was no change made to R183's care plan related to the wound change and interventions.	{F 314}		

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{F 314}	Continued From page 16	{F 314}		

On 4/7/16, at approximately 9:35 a.m. RN-B stated the NP had been notified of the increase in size of the sacrum pressure ulcer on 4/5/16. However, there was no documentation the NP or the MD was notified.

On 4/7/16, at 9:50 a.m. the NP stated he had not assessed R183's wound since he received the message (on 4/5/16) that the wound was bigger. The NP confirmed because there was an increase in size to the sacral pressure ulcer his positioning needs should have been changed.

On 4/7/16, at 9:50 a.m. a discussion was held with the DON about the tissue tolerance assessment form completed on 3/26/16. The form indicated R183's skin was red after laying in bed for two hours and then remained red when it was rechecked 30 minutes later. When asked about the assessment directive on the form which directed the assessor to consider every one to two hour repositioning if the skin was no longer reddened at the 30 minute interval check, the DON stated R183 was on an every one hour repositioning schedule when the pressure ulcer was first acquired but the care plan was changed at some point. The DON stated different nursing interventions should have been initiated and implemented immediately upon discovery when the pressure ulcer was noticed to have gotten bigger. A this time, the DON was informed about the lack of elevating heels off the bed as directed by the care plan.

-At 10:36 a.m. the DON stated the last time she

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{F 314}	Continued From page 17 had seen R138's wounds, she had informed the staff who was taking care of R138 that going two hours without repositioning was too long for him. However, the DON stated that recommendation did not get carried through. -At 10:50 a.m. the DON was asked what stage R183's sacral pressure ulcer was, and stated it was unstageable due to the slough. The DON was then asked to check with the NP or the RN who monitored the wound to see if it could now be staged. -At 11:02 a.m. a message was received from a facility office staff member stating the DON identified the wound to R183's sacrum was a stage three pressure ulcer. There was no indication as to who determined R183's current sacrum wound status. The facility Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated the facility had in place a system for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. The policy indicated a "head to toe" skin assessment would be completed on admission or within 24 hours of admission and a Tissue Tolerance test (both lying and sitting) and a Braden skin assessment would also be conducted within 24 hours of admission. All residents' were preventatively placed on a pressure reduction mattress and cushion in the wheelchair based on the skin assessment and an appropriate turning and repositioning schedule would be put in place and the care plan updated. Residents who have a loss of skin integrity would receive the appropriate treatments/services which included a repositioning or off-loading plan. Also	{F 314}		

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{F 314}	Continued From page 18 all interventions and treatments should be evaluated for efficacy and modified/changes as needed. Care plans should be revised if there was a lack of progress towards healing or when a resident acquired a new ulcer.	{F 314}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245366 Y1	A. Building B. Wing Y2	4/7/2016 Y3

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	03/29/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0246	Correction	ID Prefix F0272	Correction	ID Prefix F0279	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0280	Correction	ID Prefix F0309	Correction	ID Prefix F0310	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(1)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0323	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	LB/mm	04/14/2016	18617	04/07/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245366 Y1	A. Building B. Wing Y2	4/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0465	Correction	ID Prefix F0497	Correction	ID Prefix F0502	Correction
Reg. # 483.70(h)	Completed	Reg. # 483.75(e)(8)	Completed	Reg. # 483.75(j)(1)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0520	Correction				
Reg. # 483.75(o)(1)	Completed				
LSC	03/21/2016				

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	04/14/2016	18617	04/07/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/10/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245366 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	4/5/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 03/29/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 03/29/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 03/29/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	**REVIEWED BY (INITIALS)** LB/mm	**DATE** 04/14/2016	**SIGNATURE OF SURVEYOR** 27200	**DATE** 04/05/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/2/2016	[ ] 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

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on May 11, 2016.
May 11, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minneosta 55811

Re: Project # S5366026, H5366066

Dear Ms. Porter:

On April 7, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 10, 2016, which included an investigation of complaint H5366066 substantiated at 0830 with orders received by you electronically on March 1, 2016.

State licensing orders issued pursuant to the last survey completed on February 10, 2016 and found corrected at the time of this April 7, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on February 10, 2016, found not corrected at the time of this April 7, 2016 revisit and subject to penalty assessment are as follows:

0565-Comprehensive Plan Of Care; Use-Mn Rule 4658.0405 Subp. 3 - $300.00
0900-Rehab - Pressure Ulcers-Mn Rule 4658.0525 Subp. 3 - $350.00

The details of the violations noted at the time of this revisit completed on April 7, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $650.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected.

This written notification shall be mailed or delivered to the Department at the address below or to:

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

If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
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
	00598	A. BUILDING: _____ B. WING _____	R 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

(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: An onsite follow-up visit was completed on April 5, 6, 7, 2016 to verify correction of orders, which involved investigation of complaint number H5366066, that was substantiated at 0830 at the time of the survey on 02/10/2016. During this onsite visit it was determined that the following corrections orders/s # 0565, #0900 were NOT	{2 000}		

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{2 000}	Continued From page 1 corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s. The facility has 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 Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. 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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by."	{2 000}		

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{2 000}	Continued From page 2 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.	{2 000}		
{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: This uncorrected order will remain in effect and will be reviewed at the next onsite visit. Also uncorrected orders will be reviewed for possible penalty assessment/s. Based on observation, interview and document review, the facility failed to provide offloading services as directed by the care plan for 1 of 3 residents (R183) who required elevation of heels off bed with pillows and was observed to not receive the assistance. Findings include: R183's care plan revised on 3/19/16, indicated	{2 565}	Corrected	5/12/16

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{2 565}	Continued From page 3 R183 was at high risk for pressure ulcers / skin issues related to impaired mobility, dementia, weakness and incontinence. The plan indicated on 2/17/16, R183 had a stage two blister to the left heel which was identified on admission. An entry dated 1/20/16, indicated R183 had acquired a sacral (tail bone) ulcer which was unable to be staged. The plan directed staff to assist R183 with turn/reposition at least every two hours or more often as needed or requested, elevate heels off bed with pillows at all times, provide ROHO cushion to wheelchair, alternating pressure mattress to bed, heel protectors on at all times and to lay down after each meal. The plan indicated on 3/23/16, the alternating pressure mattress was discontinued and a Panaca with scoop mattress was initiated as a fall prevention. R183's nursing assistant care guide dated 4/6/16, directed staff to assist R183 with bed mobility and to reposition every two hours, transfer with SABINA (mechanical lift) , have heel protectors on at all times, elevate heels off the bed with pillows, had a pressure relieving mattress and pressure reducing cushion in the wheelchair. On 4/5/16, at 1:33 p.m. R183 was observed in the dining room, seated in a wheelchair, being assisted to eat lunch. R183 was observed to have bilateral white sheepskin heel protectors on both feet and a ROHO cushion in the wheelchair. -At 1:54 p.m. R183 was observed to be laying in bed, sleeping. Feet were covered with blankets. -At 2:37 p.m. staff was observed to exit R183's room. R183 was observed in bed, lying on the right side. Feet were covered with blankets. -At approximately 3:20 p.m. R183 remained in bed. Feet were uncovered and observed to be lying flat on the bed. Sheepskin protectors on.	{2 565}		

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{2 565}	Continued From page 4 -At 3:30 p.m. R183 remained in bed. Feet remained positioned flat on the bed, not elevated/offloaded on pillows as directed by the care plan. -At 3:37 p.m. registered nurse (RN)-B was asked to evaluate R183's positioning. RN-B verified R183's heels were directly on the bed with no pillow/s under his feet for elevation. RN-B placed a pillow under R183's feet however, positioned R183's feet/heels directly on top of the pillow. RN-B stated R183's feet needed to be elevated / offloaded because of the wound to his heel. On 4/6/16, at 10:25 a.m. nursing assistant (NA)-B was observed to wheel R183 to his room. NA-C and NA-B assisted R183 into bed via the mechanical lift. The NA's were asked about R183's wounds and if there were dressings on the heels. R183's heel protectors were removed and a dressing on the left side of the left heel was observed. The protectors were put back on R183's feet, however, R183's heels were placed directly on top of a pillow instead in a floating/elevated position in order to avoid any pressure on the heels. -At 11:10 a.m. R183 remained in the same position with bilateral heels resting on top of the pillow. -At 11:27 a.m. RN-B confirmed R183's heels were positioned directly on the pillow and were not floated correctly. At this same time, RN-C entered R183's room and stated R183 had regular fuzzy protective heel protectors on and maybe they should get Prevelon (pressure relieving heel boots) boots for R183. RN-B stated then maybe they could discontinue the intervention of floating the heels. -At 11:29 a.m. RN-A stated R183's pillow was not placed under R183's feet where it should be.	{2 565}		

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{2 565}	Continued From page 5 RN-A verified R183's left foot was resting on top of the pillow and not floated as directed and stated perhaps R183 needed new heel protectors. At this time, RN-C brought in a different pair of protective boots. On 4/6/16, at 8:59 a.m. the director of nursing (DON) stated she had been informed by other staff members about the observation of R183 in bed without heels being elevated off the bed therefore she had visited with NA-A and provided NA-A individual education regarding the care planned intervention of floating the heels. The DON stated the facility was very serious about implementing interventions as ordered and following the plan of care. The DON stated the morning of the observation, extra training about following the care plan was provided to all staff members. On 4/7/16, at approximately 10:00 a.m. the DON confirmed R183's heels being placed directly on a pillow did not constitute pressure relief/floating of the heels off the bed, as directed by the care plan. A policy for following the plan of care was not obtained.	{2 565}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	{2 900}		5/12/16

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{2 900}	Continued From page 6 provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: This uncorrected order will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s. Based on observation, interview and document review, the facility failed to reassess and/or modify individualized interventions following the identification of an increase in the size of a sacral pressure ulcer and failed to implement offloading interventions in order to promote the healing of a heel pressure ulcer as directed by the care plan for 1 of 3 residents (R183) reviewed who had two stage three pressure related ulcers. The failure to re-assess the sacral wound upon identification of the increase in size resulted in actual harm to R183. Findings include: R183's quarterly Minimum Data Set (MDS) dated 3/16/16, indicated R183's diagnoses included dementia, anemia, muscle weakness and chronic obstructive pulmonary disease. The MDS	{2 900}	Corrected	

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{2 900}	Continued From page 7 indicated R183 had severe cognitive impairment and required extensive assistance of two staff with bed mobility and toileting, extensive assist of one staff for transferring and personal hygiene, and did not walk. In addition, the MDS indicated R183 had one stage two (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed without slough) pressure ulcer and one unstageable pressure ulcer (surface is covered with yellow, brown, black or dead tissue. It is not possible to see how deep the wound is). R183's Braden Scale For Predicting Pressure Sore Risk (tool used to predict risk for pressure ulcers) dated 12/23/15, indicated R183 was not at risk for pressure related ulcers. R183's Pressure Ulcer Care Area Assessment (CAA) dated 12/28/15, indicated R183 was at risk for the development of a pressure ulcer/skin issues due to dementia and on 12/24/15, was noted to have a fluid filled blister. The CAA also indicated R183 was dependent on staff to meet his needs, was frequently incontinent of bladder, always incontinent of bowel, needed reminders to offload (relieving the pressure to an area) and reposition, was to wear blue boots while in bed and utilized a pressure relieving cushion in the wheelchair and bed. In addition, the CAA indicated the wound care nurse would assess R183's wound weekly. R183's Nutrition Status CAA dated 12/29/15, indicated R183 was found to have a left outer heel blister and nursing was to apply soft pillow boots to prevent further blisters. R183's Skin-Admission Skin Examination/Evaluation form dated 2/13/16, which was completed following a return from the hospital, indicated R183 had the following skin	{2 900}		

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{2 900}	Continued From page 8 issues: -Coccyx area 1.5 centimeters (cm) by 1.0 cm open area -Right side of heel open area measured 1.5 inch by 1 inch. -Left heel having 1.0 x 1.0 inch not open area, but thin. -"mushy heels" to bilateral heels. R183's Tissue Tolerance for bed form (used to determine the skin's ability to withstand pressure without change) dated 2/15/16, indicated the assessment was to be completed upon admission, annually and with significant change in status, upon emergence of a pressure ulcer, and with changes in pressure surfaces. The form indicated R183 was not independent with bed mobility and directed the assessor to follow the algorithm in order to determine positioning needs. The form directed the assessor to inspect R183's skin after remaining in the same position for two hours. At the two hour interval, R183's skin was assessed to be red and non-blanchable and directed the assessor to re-exam the skin after one hour of continuous pressure. At the one hour interval, R183's skin was assessed to no longer be reddened and directed the assessor to consider care planning for R183 to be repositioned every two hours when in bed. The bottom of the form read: Determination of positioning schedule should be done in conjunction with the Comprehensive Skin Risk Collection Tool, the Braden and resident's preferences and included in the analysis. (completed two days after return form hospital). R183's physician's orders included a wound care dressing treatment to the sacral area and left heel dated 3/14/16. The order directed staff to cleanse area with normal saline and pat dry, cut Silver	{2 900}		

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{2 900}	Continued From page 9 Calcium Alginate to fit inside wound, cover with foam dressing, change every morning and as needed. R183's Braden Scale dated 3/16/16, indicated R183 was at risk for the development of pressure related ulcers. R183's care plan revised on 1/15/16, indicated R183 did not walk, required two staff assistance for bed mobility, one staff for transfers with mechanical lift, and directed staff to observe skin with all cares and report any changes noted to nursing. A care plan problem revised on 3/19/16, indicated R183 was at high risk for pressure ulcers/skin issues related to impaired mobility, dementia, weakness, incontinence, pain, weakness, lung disease and anxiety/depression. The plan indicated on 12/17/15, R183 had a stage two blister to left heel on admit. The plan also read: 1/20/16, Unable to stage sacrum pressure ulcer acquired. The plan directed staff to assist R183 to turn/reposition at least every two hours or more often as needed or requested, elevate heels off bed with pillows at all times, provide ROHO cushion to wheelchair, alternating pressure mattress to bed, heel protectors on at all times and to lay down after each meal. The care plan included a handwritten note dated 3/23/16, which indicated the alternative pressure mattress was discontinued and a Panaca (foam) scoop mattress was initiated as a fall prevention. R183's Tissue Tolerance for bed dated 3/26/16, indicated R183 was not independent with bed mobility. At the initial two hour interval skin check, R183's skin was found be red and non-blanchable and directed the assessor to re-exam the skin after one hour of continuous pressure. At the one hour interval, R183's skin	{2 900}		

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	00598	A. BUILDING: _____ B. WING _____	R 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 900}	Continued From page 10 was assessed to remain red. The assessor was directed to recheck R183's skin in 30 minutes and if no longer reddened then consider care planning R183 to be repositioned every one to two hours when in bed. The bottom of the form read: Determination of positioning schedule should be done in conjunction with the Comprehensive Skin Risk Collection Tool, the Braden and resident's preferences and included in the analysis. However, this assessment was completed 10 days after the 3/16/16, Braden assessment was completed, no indication a Skin Risk Collection Tool was completed nor inclusion of R183's preferences. R183's physician's orders also included a treatment order from the wound nurse dated 4/4/16, which directed staff to cleanse the wounds per facility protocol, pat dry, apply skin barrier paste to wound margins, apply Calcium Alginate Silver to wound bed, cover with foam dressing, and change daily. R183's nursing assistant (NA) care guide dated 4/6/16, indicated R183 required one to two staff assistance for bed mobility, transfer with a mechanical lift, did not walk and directed staff to turn and reposition every two hours and R183 was to utilize heel protectors with heels elevated off the bed with pillows and to wear blue boots at all times. On 4/5/16, at 1:33 p.m. R183 was observed seated in a wheelchair, in the dining room being assisted with lunch. R183 was observed to have bilateral white, sheepskin heel protectors on both feet and a R0H0 cushion in the wheelchair. -At 1:54 p.m. R183 was observed lying in bed, on	{2 900}		

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{2 900}	Continued From page 11 the left side. Feet were covered with blankets. -At 2:37 p.m. a NA was observed exiting R183's room. At this time, R183 was observed in bed, laying on the right side. Feet were covered with blankets. -At approximately 3:20 p.m. R183 remained in bed. Heels were observed by the surveyor to be lying flat on the mattress without pressure relief. Sheepskin protectors were on. -At 3:30 p.m. R183 remained in bed, in the same position. Feet flat on the bed not elevated/offloaded on pillows as directed by the care plan. At this time, NA-A was asked how the staff monitored to make sure all residents were repositioned in a timely manner. NA-A removed the NA care assignment sheet out of a pocket and explained how they documented when residents received care. The sheet indicated R183 was to be repositioned every two hours, have heel protectors on and heels were to be elevated off the bed on pillows. -At 3:37 p.m. registered nurse (RN)-B was asked by the surveyor to evaluate R183's positioning. RN-B verified R183's heels were lying directly on the mattress without pillows under the feet in order to elevate/offload as directed by the care plan. RN-B stated she had completed R183's dressing change earlier and also measured the wounds and thought the wounds were bigger. RN-B took an uncovered blue pillow off a chair, lifted R183's feet and positioned R183's feet directly on top of the pillow without offloading/elevating the heels. RN-B was not observed to float/elevate R183's heels so they were not touching a surface. Following the observed positioning, RN-B stated	{2 900}		

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{2 900}	Continued From page 12 R183's feet needed to be elevated/offloaded due to the wound on his heel. On 4/6/16, at 8:38 a.m. R138 was observed to be wheeled out of his room and to the dining room for breakfast. Bilateral sheepskin heel protectors were on. R183 remained in the dining room until 10:25 a.m. -At 10:25 a.m. NA-B wheeled R183 to his room. NA-B and NA-C were observed to transfer R183 into bed via a mechanical left. When in a standing position, NA-A removed R183's incontinent brief which revealed a dressing covering the sacral area. After a clean brief was applied R183 was assisted to bed, positioned on his back. The NAs were asked about R183's wounds and if there were dressings on the heels. The NAs removed R183's heel protectors which revealed a dressing on the left side of the left heel. The heel protectors were put back on and R183's feet were placed directly on top of a pillow instead of in a floating/elevated position in order to avoid pressure on the heels. -At 11:27 a.m. R183 remained in the same position, on his back, with both heels resting on top of the pillow. RN-B confirmed R183's heels were directly on the pillow and were not floated/elevated correctly. RN-C entered the room and stated R183 had regular heel protectors on and maybe they should get Prevelon (pressure relieving heel protector) boots for him that would keep the pressure off the heels. RN-B stated then maybe they could discontinue the intervention of floating the heels. -At 11:29 a.m. R183 remained in the same position, feet not floated/elevated. RN-A was	{2 900}		

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{2 900}	Continued From page 13 observed to complete dressing changes to R183's left heel pressure ulcer. RN-B assisted with R183's positioning during the treatment. RN-A asked R183 to straighten his legs and he did not. RN-A stated R183 could not straighten his legs. The dressing to the left heel was removed with no obvious drainage noted. The heel ulcer was not measured. RN-B stated the wounds were measured once a week and were just measured the day before. The treatment and dressing change was completed to the left heel as ordered. -At approximately 11:45 a.m. RN-B removed R183's right heel protector. The heel was observed red but with no open areas. RN-B stated the heel was intact and blanchable. RN-B applied Prevelon boots that were brought in by RN-C. RN-A and RN-B repositioned R183 to his right side and RN-A completed a dressing change to the sacral area. There was a small amount of drainage noted to the old dressing and the wound appeared bright red and the skin around the wound was inflamed. The area was cleansed with normal saline, patted dry, Calcium Alginate silver dressing was applied inside the wound and the wound was covered with a foam dressing. R183's wound assessment flow sheets revealed the following on each pressure ulcer: Sacral pressure ulcer was acquired at the facility with an onset date of 1/20/16. The ulcer was initially identified as unstageable. The measurements of the sacral pressure ulcer were documented as: -2/16/16, 1.5 cm length x 1.5 cm width x depth which was blank. -2/21/16, 1.5 cm x 1.5 cm width x depth which was blank.	{2 900}		

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{2 900}	Continued From page 14 -3/7/16, 1.2 cm length x 0.8 cm width x depth which was blank. -3/14/16, 1.1 cm length x 0.5 cm width x depth which was blank. -3/21/16, 0.7 cm length x 0.6 cm width x depth which was blank. -3/31/16, 0.7 cm length x 0.6 cm width x depth which was blank. -4/5/16, 2.0 cm length (an increase in 1.3 cm from last measurement and an increase in 0.5 cm from when acquired x 1.5 cm width (an increase in 0.9 cm since last measurement) and depth measurement was blank. -A hand written progress note on the Wound Assessment Flow Sheet dated 3/7/16, skin surrounding wound blanchable (redness goes aware when pressed on), pink, no drainage noted, current treatment appears to be effective, measures 1.2 x 0.8 cm. macerated appearance surrounding top of ulcer, slough (dead tissue that may have a yellow or white appearance), no odor noted, dressing intact, clean, dry. -A hand written progress note dated 3/14/16, indicated wound measurement 1.1 x 0.5 cm. 100% slough noted to wound bed, minimum amount of drainage. Treatment changed to cleanse with normal saline, pat dry, Silver Calcium Alginate to wound bed than cover with foam dressing. -A hand written progress note dated 3/21/17, indicated wound measurement 0.7 x 0.6 cm. 80% slough noted to wound bed with 20% granulation. Minimum amount of brown drainage noted to gauze. No odor noted, surrounding skin pink in color. -A hand written progress note dated 3/31/16,	{2 900}		

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{2 900}	Continued From page 15 indicated wound size, 0.7 x 0.6 cm. 80% slough, 20 % granulation, minimum amount of drainage, brown and sanguineous (containing blood) drainage. Complained of pain, treatment changed per wound nurse. -A hand written progress note dated 4/5/16, indicated wound size 2.0 x 1.5 cm. 50% of granulation noted to wound bed with 50% slough, Surrounding skin blanchable and erythematous (redness of the skin), minimum amount of serous drainage, complained of pain, PRN pain medication given, MD (medical doctor) updated regularly in change of wound size. R183's medical record lacked documentation of the wound reassessment or MD or nurse practitioner (NP) notification of the increase in wound size. R183's care plan was not modified/revised to identify the change in wound size or any change in or new interventions. R183's left heel pressure ulcer was identified as stage three (wound with full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, muscle are not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining or tunneling) and had been acquired at the facility on 12/24/15. The measurements of the left heel pressure ulcer were documented as follows: -3/7/16, 2.5 cm length x 1.5 cm width x ___ depth, was blank. -3/14/16, 2.7 cm length x 1.7 cm width x ___ depth, was blank -3/21/16, 2.0 cm length x 1.1 cm width x ___ depth, was blank -3/31/16, 2.0 cm length x 1.0 cm width x ___ depth, was blank	{2 900}		

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{2 900}	Continued From page 16 -4/5/16, 0.9 cm length x 1.7 cm width x ___ depth, was blank -A hand written progress note on the Wound Assessment Flow Sheet dated 3/7/16, indicated wound measurements were 2.5 x 1.5 cm, skin surrounding wound blanchable, pink, no drainage noted, current treatment appears to be effective macerated appearance surrounding top of ulcer, 50% slough, 50% granulation no odor. -A hand written progress note dated 3/14/16, indicated wound measurements were 2.6 x 1.7 cm, minimum amount of serous drainage, complained of moderate pain, treatment changed to cleanse with normal saline, pat dry, Silver Calcium Alginate to wound bed than cover with foam dressing. -A hand written progress note dated 3/21/16, indicated wound measurements were 2.0 x 1.1 cm. moderate amount of brown drainage, pungent odor, wound edges macerated, denied pain. -A hand written progress noted dated 3/31/16, indicated wound measured 2 cm x 1 cm. 70% slough and 30% granulation, moderate amount of sanguineous brown drainage, macerated wound edge, complained of pain, spoke with wound nurse with no change in treatment. -A hand written note dated 4/5/16, indicated wound measured 0.9 x 1.7 cm, 50 % granulation and 50% slough. No odor noted, moderate amount of serous/greenish drainage, complained of pain, updated MD regularly in change of wound size. On 4/6/16 at 8:59 a.m. the director of nursing	{2 900}		

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{2 900}	Continued From page 17 (DON) stated she had been informed by other staff members about the observation of R183 in bed without heels being elevated off the mattress so had visited with NA-A and provided more individual education. The DON stated how serious the facility was about completing interventions as ordered. The DON stated NA-A felt bad about missing the intervention but she was a newer staff member. The DON added at that time extra training about following the plan of care was completed for nursing staff members that morning before their shifts started. During the survey on 4/6/16, R183's care plan was revised to discontinue the heel protectors and the elevation of the heels off the bed with pillows at all times and Prevalon (pressure relieving heel) boots on at all times was added to the plan. The plan had an undated handwritten entry, "Prevalon boots on @ all times " and there was a line through Elevated heels off bed with pillow at all times and heel protectors on at all times. On 4/7/16, at 9:26 a.m. the DON confirmed according to the wound measurements, the wound to R183's sacrum had increased in size and R183's medical record indicated there was no change made to R183's care plan related to the wound change and interventions. On 4/7/16, at approximately 9:35 a.m. RN-B stated the NP had been notified of the increase in size of the sacrum pressure ulcer on 4/5/16. However, there was no documentation the NP or the MD was notified. On 4/7/16, at 9:50 a.m. the NP stated he had not	{2 900}		

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{2 900}	Continued From page 18 assessed R183's wound since he received the message (on 4/5/16) that the wound was bigger. The NP confirmed because there was an increase in size to the sacral pressure ulcer his positioning needs should have been changed. On 4/7/16, at 9:50 a.m. a discussion was held with the DON about the tissue tolerance assessment form completed on 3/26/16. The form indicated R183's skin was red after laying in bed for two hours and then remained red when it was rechecked 30 minutes later. When asked about the assessment directive on the form which directed the assessor to consider every one to two hour repositioning if the skin was no longer reddened at the 30 minute interval check, the DON stated R183 was on an every one hour repositioning schedule when the pressure ulcer was first acquired but the care plan was changed at some point. The DON stated different nursing interventions should have been initiated and implemented immediately upon discovery when the pressure ulcer was noticed to have gotten bigger. A this time, the DON was informed about the lack of elevating heels off the bed as directed by the care plan. -At 10:36 a.m. the DON stated the last time she had seen R138's wounds, she had informed the staff who was taking care of R138 that going two hours without repositioning was too long for him. However, the DON stated that recommendation did not get carried through. -At 10:50 a.m. the DON was asked what stage R183's sacral pressure ulcer was, and stated it was unstageable due to the slough. The DON was then asked to check with the NP or the RN who monitored the wound to see if it could now	{2 900}		

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{2 900}	Continued From page 19 be staged. -At 11:02 a.m. a message was received from a facility office staff member stating the DON identified the wound to R183's sacrum was a stage three pressure ulcer. There was no indication as to who determined R183's current sacrum wound status. The facility Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated the facility had in place a system for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. The policy indicated a "head to toe" skin assessment would be completed on admission or within 24 hours of admission and a Tissue Tolerance test (both lying and sitting) and a Braden skin assessment would also be conducted within 24 hours of admission. All residents' were preventatively placed on a pressure reduction mattress and cushion in the wheelchair based on the skin assessment and an appropriate turning and repositioning schedule would be put in place and the care plan updated. Residents who have a loss of skin integrity would receive the appropriate treatments/services which included a repositioning or off-loading plan. Also all interventions and treatments should be evaluated for efficacy and modified/changes as needed. Care plans should be revised if there was a lack of progress towards healing or when a resident acquired a new ulcer.	{2 900}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00598 Y1	A. Building B. Wing Y2	4/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20255	Correction	ID Prefix	20285	Correction	ID Prefix	20550	Correction
Reg. #	MN Rule 4658.0070	Completed	Reg. #	MN Rule 4658.0100 Subp. 2	Completed	Reg. #	MN Rule 4658.0400 Subp. 4	Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		03/21/2016
ID Prefix	20555	Correction	ID Prefix	20560	Correction	ID Prefix	20830	Correction
Reg. #	MN Rule 4658.0405 Subp. 1	Completed	Reg. #	MN Rule 4658.0405 Subp. 2	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		03/21/2016
ID Prefix	20915	Correction	ID Prefix	21015	Correction	ID Prefix	21375	Correction
Reg. #	MN Rule 4658.0525 Subp. 6 A	Completed	Reg. #	MN Rule 4658.0610 Subp. 7	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		03/21/2016
ID Prefix	21426	Correction	ID Prefix	21530	Correction	ID Prefix	21540	Correction
Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN Rule 4658.1310 A.B.C	Completed	Reg. #	MN Rule 4658.1315 Subp. 2	Completed
LSC		03/21/2016	LSC		03/21/2016	LSC		03/21/2016
ID Prefix	21620	Correction	ID Prefix	21685	Correction	ID Prefix	21810	Correction
Reg. #	MN Rule 4658.1345	Completed	Reg. #	MN Rule 4658.1415 Subp. 2	Completed	Reg. #	MN St. Statute 144.651 Subd. 6	Completed
LSC		04/07/2016	LSC		03/21/2016	LSC		03/21/2016

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	LB/mm	05/11/2016	18617	04/07/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00598 Y1	A. Building B. Wing Y2	4/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21980	Correction				
Reg. # MN St. Statute 626.557 Subd. 3	Completed				
LSC	03/21/2016				

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	05/11/2016	18617	04/07/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/10/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 43LY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00598

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245366**
2.STATE VENDOR OR MEDICAID NO.
(L2) **175040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHRIS JENSEN HEALTH & REHABILITATION CENTER**
(L4) **2501 RICE LAKE ROAD**
(L5) **DULUTH, MN** (L6) **55811**

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) **11/01/2009**

6. DATE OF SURVEY **02/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **170** (L18)
13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Rebecca Haberle, HFE NEII — 03/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 03/23/2016 (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
08/01/1986
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5366

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the February 10, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5366066 that was found to be substantiated at F323. As a result of the survey, this Department imposed the following Category 1 remedy:

State Monitoring effective March 5, 2016

In addition, the Department recommended the following enforcement remedies to the CMS Region V office for imposition:

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for all Medicare and Medicaid admissions effective April 10, 2016

The facility is subject to a two year loss of NATCEP, beginning February 10, 2016, as a resut of the extended survey that identified substandard quality of care.

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered
February 29, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366026, H5366066

Dear Ms. Porter:

On February 10, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 10, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5366066.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care (SQC) and immediate jeopardy (IJ)** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the February 10, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5366066 that was found to be substantiated at F323.

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

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

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on February 5, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

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

NO OPPORTUNITY TO CORRECT - REMEDIES

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

- State Monitoring effective March 5, 2016. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

- Discretionary denial of payment for all Medicare and Medicaid admissions effective April 10, 2016. (42 CFR 488.418 (a))

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Chris Jensen Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 10, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R.

968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be

discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 10, 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 August 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended survey was conducted by the Minnesota Department of Health on February 1, 2016, through February 10, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to complete ongoing assessments to determine causal factors and implement interventions for a resident with increased mobility and continued unsafe independent transfers / ambulation and had sustained two neck fractures as a result of a fall on 2/2/16. The lack of assessment placed the resident at significant risk for serious injury and / or death. The facility administrator and director of nursing (DON) were notified of IJ on 2/3/16, at 7:25 p.m., which began on October 15, 2015, when the facility identified R180 went from a low risk for falls to a high risk for falls due to increased mobility and unsafe transfer / ambulation without a comprehensive assessment of causal factors related to self transfers / rising in order to minimize R180's risk for further falls. The IJ was removed on 2/5/16, at 2:05 p.m., however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R180 due to a neck fractures sustained during a fall which required medical interventions. In addition, a complaint investigations was completed for complaint number H5366066 while on-site. The complaint was substantiated. Deficiency(ies) issued at F323 resulting in an IJ. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 03/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

(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	Continued From page 1 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current, complete State survey results were posted in an area readily accessible to residents, families and visitors. This had the potential to affect all 140 residents currently residing in the facility. Findings include:	F 167	Validation of all survey books have been completed to assure that all results are in the books. Life safety code deficiencies during the 2015 survey has been added Wooden holder has been updated to reflect previous survey findings. All resident may be affected, but none show any ill effect.	3/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 167	Continued From page 2 On 2/1/16, at 4:00 p.m. during the initial facility tour, a white three ring binder was observed in an unmarked wooden holder on the ground floor outside of the business office. The label on the binder was not visible due to the manner the binder was placed in the wooden holder. Upon removal of the white binder, which had been attached to the wooden holder by a plastic cord, the front cover indicated the binder held State survey results. The binder included survey results dated 5/20/15, 7/21/15, and 9/9/15, however, lacked the results of the life safety code deficiencies which had been cited during the 5/20/15, survey. On 2/2/16, at 1:42 p.m. the director of nursing (DON) stated the facility had the most recent survey results posted in two locations, on the ground floor by the main entrance and on the first floor at the upper entrance. At the upper entry entrance the survey results had been placed in a white binder, located in a wooden holder adjacent to the information desk. Upon removal of the white binder, the DON verified the life safety code results from the 5/20/15, survey where not in the survey binder. On 2/2/16, at 1:50 p.m. the DON verified the white survey binder placed outside of the business office on the main floor also lacked the results of the life safety code deficiencies which had been cited during the 5/20/15, survey. The DON confirmed both of the survey result binders should have included the life safety code results. On 2/2/16, at 2:10 p.m. the administrator confirmed the life safety code survey results had not be printed and should have been included in	F 167	Education was provided to staff of posting survey results. Survey Posting Audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of audits to QAA committee. It is the responsibility of the Director of Nursing or designee to ensure compliance. Date Certain 3/29/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 167	Continued From page 3 the binder. On 2/2/16, at 4:43 p.m. the DON confirmed the facility did not have a policy regarding the posting of survey results, however, the expectation would be the facility would follow the State and federal regulations.	F 167		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		3/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 225	Continued From page 4 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 bruises of unknown origin to the State agency for 2 of 5 residents (R78, R180) reviewed for abuse prohibition and found to have bruises of unknown origin not reported the State agency. Findings include: R78's bruise of unknown origin was not immediately reported to the SA. The Resident Incident Report, completed by licensed practical nurse (LPN)-C on 12/29/15, indicated R78 was noted to have a very large bruised area under the right arm just below the right elbow, through the axilla area extending down and engulfing most of the right breast and also down into ribs. R78 was also noted to have a greater than 10 centimeter (cm) bruise to the top of her left hand. The bruised areas were of unknown origin. R78 was described as not in pain unless her breast area was touched. The incident report indicated the physician and family were notified on 12/29/15. The report did not identify when the administrator was notified, however the administrator signed the report on 1/11/16. The Vulnerable Adult Reporting section	F 225	Resident 180 and 78 had no ill effect related to the injury of unknown origin not being reported. All resident may be affected by a change in condition related to injury or unknown origin not being reported, but none show any negative outcome. Staff have been re-educated on facility policy on abuse prevention with emphasis on immediate reporting to the administrator and to the required state agency of any injuries of unknown source. DON will maintain a current log of reportable issues and events. Reporting of unknown origin audit will be completed daily x 3 months and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Administrator or designee to ensure compliance.	

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	245366	A. BUILDING _____ B. WING _____	02/10/2016

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F 225	Continued From page 5	F 225		

of the incident report identified an "x" placed next to the "No" choice for Reported to CEP [common entry point].

R78's Interdisciplinary Note dated 12/29/15, indicated R78 was found with bruising to the right side of her body with very dark bruising starting from just below elbow up through axilla area, extending down under arm and engulfing most of her right breast. The note also indicated R78 had bruising to the top of her left hand. The note indicated the physician and director of nursing (DON) were notified and investigation started as the bruise was of unknown origin.

On 02/05/2016, at 11:32 a.m. the DON verified the bruises were identified on 12/29/15, at 12:25 a.m. and the unit manager investigated the incident when she came on duty for the morning shift. The DON confirmed the bruises were of unknown origin and should have been reported to the SA immediately but had not been reported at all.

R180 was noted to have a bruises of unknown origin which were not reported to the SA, as required.

A Resident Incident Report completed by registered nurse (RN)-A on 7/13/15, indicated R180 was noted to have a 9.0 cm by 5.0 cm bruise to the upper left arm. R180 did not complain of pain and was identified as being "unreliable" to report how the bruise had occurred. The rest of the incident report was blank.

R180's The Nurse's Record & Progress Notes dated 7/13/15, at 2:00 p.m. indicated a 5.0 cm x

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9.0 cm bruise was noted on R180's left arm. The note also indicated R180 was unable to communicate when the bruise occurred. No further investigation of the bruise was noted in the clinical record.

A Resident Incident Report completed on 12/2/15, indicated R180 was found to have a 4.0 cm x 4.5 cm bruise on the center / mid back and a 7.0 cm x 7.0 cm bruise on the left hip. The report indicated the bruises were of unknown origin, R180 denied pain and was unable to state how or when she had received the bruises. The RN supervisor section indicated R180 had been more ambulatory and may have fallen.

R180's The Nurse's Record & Progress Notes dated 12/9/15, at 2:00 p.m. identified the 9.0 cm x 5.0 cm bruise on R180's left arm. The note also indicated R180 was unable to communicate when the bruise occurred.

On 2/3/16, at 12:50 p.m. RN-A verified R180's bruises were of unknown origin. She stated when bruises of unknown origin were identified, she completed an incident report regarding the bruises. She stated she was unaware if the bruises had been reported to the State Agency. She also stated she did not know how to report concerns to the SA as the only employees who reported concerns to the SA were the licensed social worker and the DON.

On 2/3/15, at 1:42 p.m. the DON verified the aforementioned bruises were of unknown origin and should have been reported to the SA, as required.

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F 225	Continued From page 7 The Abuse Prevention/Resident Treatment policy dated 4/1/08, defined abuse as the willful infliction of injury with resulting physical harm and physical abuse to include hitting, slapping, pinching and kicking. The policy indicated an injury should be classified as an "injury of unknown source" if the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy directed all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property were to be reported immediately to the administrator of the facility and were also to be reported immediately to the SA in accordance with existing state law. The facility investigated each alleged violation thoroughly and reported the results of all investigations to the administrator as well as to SA's as required by stated and federal law.	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	F 226	Resident 180 and 78 had no ill effect	3/21/16

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F 226	Continued From page 8 facility failed to implement their abuse policy related to the immediate reporting of injuries of unknown origin (bruises) to the State agency for 2 of 5 residents (R78, R180) reviewed for abuse prohibition. Findings include: The Abuse Prevention/Resident Treatment policy dated 4/1/08, defined abuse as the willful infliction of injury with resulting physical harm and physical abuse to include hitting, slapping, pinching and kicking. The policy indicated an injury should be classified as an "injury of unknown source" if the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy directed all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property were to be reported immediately to the administrator of the facility and were also to be reported immediately to the State agency (SA). R78's bruise of unknown origin was not immediately reported to the SA agency as required. The Resident Incident Report, completed by licensed practical nurse (LPN)-C on 12/29/15, indicated R78 was noted to have a very large bruised area under the right arm just below the right elbow, through the axilla area extending down and engulfing most of the right breast and	F 226	related to the injury of unknown origin not being reported. All resident may be affected by a change in condition related to injury or unknown origin not being reported, but none show any negative outcome. Staff re-educated on facility policy on abuse prevention with emphasis on immediate reporting to the administrator and to the required state agency of any injuries of unknown source. The DON will maintain a current log of reportable issues and events. Reporting of unknown origin audit will be completed daily x 3 months and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Administrator or designee to ensure compliance.	

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F 226	Continued From page 9	F 226		

also down into ribs. R78 was also noted to have a greater than 10 centimeter (cm) bruise to the top of her left hand. The bruised areas were of unknown origin. R78 was described as not in pain unless her breast area was touched. The incident report indicated the physician and family were notified on 12/29/15. The report did not identify when the administrator was notified, however the administrator signed the report on 1/11/16. The Vulnerable Adult Reporting section of the incident report identified an "x" placed next to the "No" choice for Reported to CEP [common entry point].

R78's Interdisciplinary Note dated 12/29/15, indicated R78 was found with bruising to the right side of her body with very dark bruising starting from just below elbow up through axilla area, extending down under arm and engulfing most of her right breast. The note also indicated R78 had bruising to the top of her left hand. The note indicated the physician and director of nursing (DON) were notified and investigation started as the bruise was of unknown origin.

On 02/05/2016, at 11:32 a.m. the DON verified the bruises were identified on 12/29/15, at 12:25 a.m. and the unit manager investigated the incident when she came on duty for the morning shift. The DON confirmed the bruises were of unknown origin and should have been reported to the SA immediately but had not been reported at all.

R180's bruises of unknown origin which were not reported to the SA, as required.

A Resident Incident Report completed by registered nurse (RN)-A on 7/13/15, indicated

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F 226	Continued From page 10	F 226		

R180 was noted to have a 9.0 cm by 5.0 cm bruise to the upper left arm. R180 did not complain of pain and was identified as being "unreliable" to report how the bruise had occurred. The rest of the incident report was blank.

R180's The Nurse's Record & Progress Notes dated 7/13/15, at 2:00 p.m. indicated a 5.0 cm x 9.0 cm bruise was noted on R180's left arm. The note also indicated R180 was unable to communicate when the bruise occurred. No further investigation of the bruise was noted in the clinical record.

A Resident Incident Report completed on 12/2/15, indicated R180 was found to have a 4.0 cm x 4.5 cm bruise on the center / mid back and a 7.0 cm x 7.0 cm bruise on the left hip. The report indicated the bruises were of unknown origin, R180 denied pain and was unable to state how or when she had received the bruises. The RN supervisor section indicated R180 had been more ambulatory and may have fallen.

R180's The Nurse's Record & Progress Notes dated 12/9/15, at 2:00 p.m. identified the 9.0 cm x 5.0 cm bruise on R180's left arm. The note also indicated R180 was unable to communicate when the bruise occurred.

On 2/3/16, at 12:50 p.m. RN-A verified R180's bruises were of unknown origin. She stated when bruises of unknown origin were identified, she completed an incident report regarding the bruises. She stated she was unaware if the bruises had been reported to the State Agency. She also stated she did not know how to report

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F 226	Continued From page 11 concerns to the SA as the only employees who reported the concerns to the SA were the licensed social worker and the DON. On 2/3/15, at 1:42 p.m. the DON verified the aforementioned bruises were of unknown origin and should have been reported to the SA, as required.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a table adequate for dining for 1 of 2 residents (R133) observed to eat meals in her room without a table for placement of her meal. Findings include: R133's quarterly Minimum Data Set (MDS) dated 12/20/15, indicated R133 was cognitively intact and was independent with eating.	F 246	Resident 133 has been assessed and a proper table adequate for dining has been provided. Staff re-education regarding accommodation of need expectations have been provided. All residents may be affected by not having an adequate table for dining, but none show any negative outcome. Accommodation of Needs audits will be completed weekly X 3 month and then reevaluated by QAA.	3/21/16

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F 246	Continued From page 12 R133's care plan dated 10/13/2015, indicated R133 could feed herself and directed staff to arrange place setting, apply condiments, cut meat, pour liquids and encourage R133 to finish meal as directed by resident. On 02/03/2016, at 8:41 a.m. R133 was observed eating breakfast in her room. A tray with a napkin, coffee cup and knife were observed on the bed while R133 sat in her electric wheelchair which facing the bed. R133 was balancing a plate inside a plate warmer on her chest, holding them with her left hand, while eating a waffle with her right hand. A half eaten bowl of hot cereal was observed on top of the closed lid of a commode which was at R133's the bedside. R133 stated she could use a table for her tray but thought they were all being used. An over the bed table was observed against the wall across the room from R133's bed. A lamp and decorations were placed on top of the over the bed table. On 02/03/2016, at 12:51 p.m. R133 was observed eating lunch in room. Her lunch tray with plate, utensils, glass of fluid and napkin was placed on R133's bed. R133 stated she liked to eat in her room as she enjoyed watching television during her meal. A half full coffee cup was observed placed on the closed lid of a commode at R133's bedside. Several dried coffee cup rings were observed on the lid of the commode. On 02/05/2016, at 8:51 a.m. R133 was observed	F 246	DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 246	Continued From page 13 eating breakfast in her room. The breakfast tray was placed on the bed. On 02/05/2016, at 9:56 a.m. nursing assistant (NA)-R was observed picking up resident breakfast trays. NA-R stated R133 often ate in her room, used her bed for her meal tray and that R133 liked to have her tray placed on her bed. NA-R confirmed R133 put items from her meal tray on the commode and stated the practice was not sanitary. On 02/05/2016, at 9:58 a.m. R133 stated she would like to have a table for her meal tray and stated she was scared she would spill on the bed. On 02/05/2016, at 10:49 a.m. registered nurse (RN)-F confirmed R133 should be provided a table for her meal tray and placing items on the commode was not sanitary. RN-F indicated there were tables available for R133's use. On 02/05/2016, at 11:30 a.m. the director of nursing (DON) confirmed R133 should have a table to use for her meal tray. The Accommodation of Needs policy dated 4/1/2008, indicated a resident had the right to reside and receive services in the facility with reasonable accommodations for individual needs and preferences, except when safety of the individual or other residents would be endangered.	F 246		

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F 272	Continued From page 14	F 272		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		3/21/16

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F 272	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately reflect limitations in range of motion on the quarterly Minimum Data Set (MDS) for 1 of 3 residents (R52) observed with limitations in range of motion. Findings include: R52's quarterly MDS dated 1/17/16, indicated R52 had no impairment for functional limitation for range of motion (ROM) on upper (shoulder, elbow, wrist, hand) or lower (hip, knee, ankle, foot) extremities. R52's physician progress note dated 1/13/16, indicated R52's diagnoses included cerebral vascular accident (stroke) and left contracture. In addition, the physical exam indicated R52's left upper extremity had a flexion deformity and the shoulder on the left had little movement. R52's care plan dated 11/5/15, indicated under the focus areas of activities of daily living and pain that R52 had a hand contracture. On 2/1/16, at 7:30 p.m. R52 was observed lying in bed with a lamb's wool covered splint on the left hand. R52 stated she wore the splint all the	F 272	Resident 52 Minimum Data Set (MDS) has been reviewed and corrections completed. Other residents with contractures have been reviewed for correct coding regarding ROM. System for tracking ROM MDS entry for accuracy has been devised and education provided to MDS team. All residents may be affected by improper coding for ROM, but none show any negative outcome. MDS Audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or Designee to ensure compliance.	

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F 272	Continued From page 16 time. R52's Occupational Therapy (OT) Initial Evaluation dated 12/16/15, indicated R52 had a contracture in her left hand. In addition, R52's ROM in her left upper extremity (shoulder, elbow/forearm, wrist and hand) were all impaired. On 2/4/16, at 10:33 a.m. certified occupational therapy assistant (COTA)-A confirmed R52 had worn a palm protector and splint on the left hand for at least six months. COTA-A verified R52 currently had a left hand contracture. On 2/4/16, at 11:20 a.m. registered nurse (RN)-G confirmed R52's quarterly MDS dated 1/17/16, identified R52 as having no upper or lower extremity ROM limitations and stated all other previous MDS reviews had indicated impairment. On 2/4/16, at 1:05 p.m. RN-G verified R52's quarterly MDS dated 1/17/16, inaccurately reflected R52's impairment for functional limitation for ROM on the upper and lower extremities. The Long Term Care Facility Resident Assessment Instrument (RAI) manual dated 10/2015, indicated the three components of the RAI yielded information regarding a resident's functional status, strengths and weaknesses. The MDS included a core set of screening, clinical, and functional status elements which formed the foundation of a comprehensive assessment for all	F 272		

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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 272	Continued From page 17 residents. The primary purpose of the RAI tool was to identify resident care problems that were addressed in the individualized care plan. The RAI directed the assessor to code functional limitation in ROM of A: upper extremity (shoulder, elbow, wrist, hand) or B: lower extremity (hip, knee, ankle, foot) that interfered with daily functions or placed the resident at risk for injury. The assessor was further instructed to code the RAI in the following manner: 0 for no impairment; 1 for impairment on one side; 2 for impairment on both sides.	F 272		
F 279 SS=E	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	F 279		3/21/16

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F 279	Continued From page 18 by: Based on observation, interview and document review, the facility failed to develop a care plan which identified smoking and interventions for the safe storage of tobacco products and fire materials for 1 of 2 residents (R95) reviewed for safe smoking. In addition, the facility failed to develop the care plan which included target behaviors and non pharmalogical interventions for 3 of 3 residents (R139, R136, R153) receiving as needed antipsychotic and antianxiety medications. Findings include: R95's utilized smoking materials and her care plan was not developed to identify a smoking plan nor the safe storage of the materials. R95's annual Minimum Data Set (MDS) dated 1/10/16, indicated R95 was cognitively intact, required supervision off and on the unit and had current tobacco use. R95's Smoking Safety Assessment, dated 1/13/16, indicated, R95 was able to move without assistance to / from designated smoking areas, able to use ashtray to self-extinguish cigarettes, could use lighter or matches safely, had history of smoking-related incidents such as burned clothing. Interventions identified R95 was independent with smoking, utilized a smoking apron and was instructed and understood facility smoking policy and was identified on the care plan.	F 279	Resident 95 no longer resides at Chris Jensen. Care plans for smoking residents updated to include storage of smoking materials according to their assessment. Education has been provide to staff related to the new smoking policy. Resident 139 care plan has been reviewed and updated to include targeted behaviors and non-pharmacological interventions for her PRN medication. Resident 136 care plan has been reviewed and updated to include targeted behaviors and non-pharmacological interventions. Resident 153 care plan has been reviewed and updated to include targeted behaviors and non-pharmacological interventions for his PRN medication. All smoking residents may be affected, but none show any negative outcome. Education has been provided to include targeted behaviors and non-pharmacological interventions on the care plan to nursing and social service staff. Audits of targeted behaviors and non-pharmacological interventions along with care plans for smoking resident will be completed weekly x 3 months and then re-evaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of	

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F 279	Continued From page 19 R95's Resident Smoking Agreement, dated 6/30/15, indicated, all residents who wish to smoke during their stay will receive a smoking assessment and a signed copy of the smoking guidelines. All smoking materials must be kept secure for the safety of all residents. We recognize there are special circumstances and other options will be designed for individual situations. If the smoking assessment demonstrates the resident is able to safely smoke independently, by meeting all of the conditions described in the assessment, the resident's care plan will be revised to include the resident's wishes to smoke. The signed agreement did not identify any special circumstances. R95's Resident Smoking Guidelines dated 6/30/15, indicated, all smoking materials must be kept secure for the safety of all residents. We recognize there are special circumstances and other options will be designed for individual situations. The Guidelines lacked any special circumstances. On 2/2/16, at 8:24 a.m. R95's over the bed table was observed from the Elm wing hallway outside of R95's room. A tray with one 16 ounce bag of loose tobacco, a cigarette rolling machine, 20 filtered cigarettes, a purple cigarette box, three cigarette lighters and loose tobacco which covered the tray was observed on R95's overbed table. R95 was not in the facility at this time as had been admitted to the hospital on 1/25/16.	F 279	Nursing to ensure compliance. .	

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F 279	Continued From page 20 On 2/2/16, at 1:35 p.m. R95's over the bed table continued to contain the 16 ounce bag of tobacco, a cigarette roller, the purple cigarette box, 20 filtered cigarettes, and three cigarette lighters. A strong tobacco odor was noted in R95's room. On 2/2/16, at 1:40 p.m. R95 returned from the hospital. On 2/2/16, at 2:13 p.m. R95 stated she rolled her own cigarettes and was heading to the facility smoking area. R95 was observed to put on her jacket, pick up three cigarette lighters and the purple cigarette box and put them into her jacket pocket and left for the smoking area. The bag of tobacco, cigarette roller, 20 cigarettes and loose tobacco remained on the over the bed tray / table. On 2/2/16, at 7:30 p.m. R95 was readmitted to the hospital. On 2/3/16, at 11:28 a.m. R95's smoking products, a 16 ounce bag of tobacco, cigarette rolling machine and loose tobacco were observed on R95's over bed table / tray. Family member (FM)-A stated R95's smoking material was always left out in the open, even when R95 was not in the facility. FM-A stated R95's room always smelled like tobacco. On 2/3/16, at 3:36 p.m. licensed practical nurse (LPN)-B stated she was not sure what R95's care plan indicated regarding R95's smoking or	F 279		

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smoking products or where she was suppose to keep them. LPN-B verified the R95's smoking products, tobacco, roller, cigarettes and loose tobacco were on a tray on the over the bed table in R95's room and not securely stored. LPN-B stated she was not sure what was supposed to be done with them. LPN-B also stated the other resident who smoked on this wing locked them in his in a drawer. LPN-B verified there were residents who had confusion and wandered on the wing.

On 2/3/16, at 3:40 p.m. registered nurse (RN)-D stated she did not know what the smoking plan was or how R95's smoking materials were supposed to be secured. RN-D stated she knew when R95 was in the facility, the materials were not secured.

On 2/3/16, at 3:44 p.m. the director of nursing (DON) stated she was unsure what R95's smoking plan was and would check the policy and find the information for R95's plan for smoking and storage. The DON verified R95 was readmitted to the hospital last night and was not currently in the facility. The DON stated she would go and put R95's smoking materials away.

On 2/3/16, at 5:59 p.m. the DON verified R95's care plan did not reflect a smoking plan. The DON also verified smoking products should have been secured, especially when a resident was not in the facility.

On 2/3/16, at 7:08 p.m. the DON stated R95's

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F 279	Continued From page 22 care plan should have reflected her smoking plan including tobacco product storage. R139 received as needed (PRN) lorazepam (antianxiety) medication and the facility failed to develop a comprehensive care plan which identified target behaviors and non-pharmacological interventions to be attempted prior to the administration of the medication. R139's Physician Order sheet dated 1/12/16, indicated R139 had diagnoses which included acute confusional state and dementia. The order sheet also indicated R139 was prescribed Seroquel (antipsychotic) 25 mg (milligrams) twice a day and lorazepam (ativan / antianxiety) 0.5 mg 1/2 tablet twice daily, as needed. R139's care plan dated 1/28/16, identified a focus area for psychotropic drug use. The interventions included medication as ordered, observe for medication effectiveness, abnormal involuntary movement scale (AIMS) per facility policy. However, the care plan lacked identification of target behaviors and nonpharmacological interventions to be attempted prior to the administration of the PRN lorazepam. R139's medication administration record (MAR) indicated R139 had received lorazepam on 12/8/15, 12/18/15, 1/1/16, 1/4/16, 1/9/16, 1/13/16, 1/21/16, and 1/30/16. however, the record lacked documentation related to what	F 279		

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F 279	Continued From page 23 non-pharmacological interventions had been attempted prior to the use of the medication. On 2/3/16, at 8:15 a.m. RN-E stated R139 had not utilized her PRN Ativan in February to date, but did use it in January. RN-E stated she would use the PRN medication if R139 had increased anxiety and would document on the MAR it was given for anxiety. RN-E further stated she did not document any where what she did before giving the medication. RN-E stated she did not know what R139's target behaviors were or non pharmacological interventions to be attempted prior to the use of the Ativan. RN-E stated it was not identified on the MAR. On 2/3/16, at 1:50 p.m. RN-D stated R139 received PRN lorazepam, but did not know what R139's target behaviors or non-pharmacological interventions were. RN-D verified there was no information on R139's MAR, or care plan identifying target behaviors and non pharmalogical interventions to be attempted prior to the use of the PRN lorazepam. On 2/3/16, at 2:03 p.m. the licensed social worker (LSW) stated target behaviors and non-pharmacological interventions should have been listed on R139's MAR. LSW stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which should have been on the MAR for monitoring and implementation of interventions prior to PRN medication use. The LSW verified R139's medical record, MAR and care plan lacked target	F 279		

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F 279	Continued From page 24 behaviors and non-pharmacological interventions and stated they should have been there. On 2/3/16, at 2:33 p.m. the DON verified R139's target behaviors and nonpharmacological interventions should have been identified on R139's care plan. R136 was prescribed risperidone (Risperdal) (antipsychotic) as needed, the facility failed to ensure a comprehensive care plan was developed identifying target behaviors and non pharmalogical interventions to be attempted prior to the administration of the as needed risperidone medication. R136's Integrated Problem List/Diagnostic Records sheet undated, indicated R136 had diagnoses which included, dementia with paranoid thoughts and diabetes. R136's physician orders dated 1/31/16, and 12/3/15, indicated R136 was to receive risperidone 0.25 mg twice a day and 0.5 mg 1/2 tablet twice daily PRN. R136's care plan identified a focus area for psychotropic drug use revised 1/18/16, which indicated R136 had Alzheimer's dementia with behaviors and paranoia, received scheduled antipsychotic and antidepressant medications with a failed dose reduction of both meds 3/15. The interventions included medication as ordered, observe for medication effectiveness,	F 279		

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abnormal involuntary movement scale (AIMS) per facility policy. In addition, the care plan indicated a Mood / Behavior focus area revised on 8/20/15, which indicated R136 wandered, became paranoid and believed others had stolen her belongings. The plan indicated R136 was easily directed. The plan directed staff to listen to R136's concerns, acknowledge feelings, provide reassurance, redirect when in other resident rooms, check for thirst/toileting/ pain/hunger and encourage activities. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN risperidone.

R136's MAR indicated R136 was administered risperidone 0.5 mg 1/2 tablet bid three times in January on 1/5/16, 1/8/16, and 1/9/16, for increased anxiety. No use in February to date.

R136's medical record lacked Target Behavior Flow Sheets.

On 2/4/16, at 10:56 a.m. RN-C stated R136's MAR did not identify any target behaviors nor non-pharmacological interventions to be attempted prior to the use of the PRN medication. RN-C stated she had seen those for others which was usually identified on the MAR. RN-C verified R136 did not have any listed. RN-C stated she could list the interventions that work for R136 but they were just not identified.

On 2/4/16, at 1:59 p.m. RN-B stated target

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behaviors and non-pharmacological interventions should have been identified for R136 and staff were expected to attempt and document as well. RN-B verified there were no target behaviors or non-pharmacological interventions identified in R136's record, or on the care plan.

On 2/3/16, at 2:03 p.m. the LSW-A stated target behaviors and non-pharmacological interventions should have been listed on R136's MAR right below the medication. LSW-A stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which should have been on the MAR for monitoring and implementation of interventions prior to PRN medication use.

On 2/3/16, at 2:33 p.m. the DON verified target behaviors and non-pharmacological interventions should have been identified and attempted prior to administering R136's PRN risperidone and R136's care plan should have reflected that.

R153 was administered PRN Seroquel and the facility failed to ensure a comprehensive care plan was developed identifying target behaviors and non pharmalogical interventions to be attempted prior to the administration of the as needed antipsychotic medication.

R153's Physician Order sheet dated 2/4/16, indicated R153 had diagnoses which included Parkinson's disease, chronic obstructive pulmonary disease (a lung condition), and Lewy

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F 279	Continued From page 27 Body dementia (an aggressive dementia which can cause hallucinations, rigid muscles, slowed movement and tremors). R153's physician orders dated 2/4/16, included the following: - Seroquel 50 mg (milligrams) twice a day which was started 5/22/15. - Seroquel 100 mg at bedtime which was started 7/8/15. - Seroquel 50 mg PRN up to three times a day which was started 9/15/14. - Gabapentin (anticonvulsant medication) 100 mg three times a day which was started 10/14/14. - Trazodone (antidepressant) 75 mg daily started on 11/21/14. R153's care plan dated 11/25/15, identified a focus area for psychotropic drug use related to agitation with severe encephalopathy, severe Parkinsonism and Lewy body dementia which was initiated on 9/25/14. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, abnormal involuntary movement scale (AIMS) per facility policy and review for potential side effects. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN Seroquel. The care plan also identified a focus area for mood and behavior which indicated R153 displayed hitting and swearing with cares. The interventions included offer to walk the resident, leave the resident alone and return, try a different caregiver, try a different approach and offer apple juice.	F 279		

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R153's Target Behavior forms for 12/1/15 - 2/4/16, identified R153's target behavior as hitting and swearing at staff with cares. Approaches identified included secure others and resident safety and leave resident alone, wait ten minutes and return, try a different caregiver, speak calmly and slowly.

R153's nursing progress notes and behavior sheets were reviewed and revealed R153 received Seroquel 50 mg PRN 14 times from 12/1/15 - 2/4/16. The medical record lacked the following information related the use of the PRN Seroquel:

-Documentation of target behaviors (hitting and swearing at staff with cares) six out of the 14 times 12/10/15, and 12/14/15 (R153 was given 3 doses on this day), 12/17/15, 12/20/15, 1/14/16) all lacked target behaviors resulting in the administration of the PRN medication.
-Documentation of non-pharmacological interventions trialed prior to the administration of the PRN Seroquel eight out of 14 times on 12/7/15, 12/10/15, 12/14/15 (given three doses only documentation for one dose), 12/17/15, 12/19/15, 12/20/15, and 1/14/16.

On 2/4/16, at 2:43 p.m. R153 was observed seated in his tilt back wheelchair stationed on the outskirts of the nursing station. R153 was alert, calm and watched as other staff and residents passed by.

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F 279	Continued From page 29 On 2/5/16, at 1:16 p.m. LPN-D verified R153 had PRN Seroquel ordered. LPN-D stated R153 usually received the PRN Seroquel four to five times a month when R153 exhibited behaviors such as hitting or punching staff. When asked about non-pharmacological interventions, LPN-D stated they could offer R153 apple juice or give him a ride in his wheelchair. LPN-D stated overall, the staff could do a better job of documenting the target behaviors exhibited and non-pharmacological interventions attempted. On 2/5/16, at 1:41 p.m. RN-B confirmed the expectation was for staff to document the specific behavior exhibited by R153 and the non-pharmacological interventions trialed prior to the administration of the PRN Seroquel. In addition, target behaviors and non-pharmacological interventions should specifically be identified on the care plan. RN-B confirmed R153's care plan lacked these specifics. On 2/5/16, at 2:02 p.m. consulting pharmacist (CP)-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R153's PRN Seroquel. The facility Care Plans policy dated 4/1/2008, indicated the facility develops a comprehensive care plan for each resident including measurable objective and timetables to meet the medical, nursing, mental and psychosocial needs, as identified in the comprehensive assessments.	F 279		

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F 280	Continued From page 30	F 280		
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. 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 non-weight bearing status and changes in mode of transfers for 1 of 4 residents (R185) reviewed for accidents. Findings include: On 2/3/16, at 1:20 p.m. R185 was observed in her room, seated in a motorized wheelchair. A	F 280	Resident 185 care plan has been reviewed and updated to reflect non-weight bearing status on Right foot and change in mode of transfers. Audit has been completed to ensure all residents have a care plan in place related to transfers and to include weight bearing status if indicated. All residents may be affected by not updating their care plan for non-weight bearing status, but none show any	3/21/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 280	Continued From page 31 nonskid mat was located on the bathroom floor directly in front of the toilet. R185 had nonskid footwear on her left foot and an ace wrapped splint on the right foot/leg. R185's significant change Minimum Data Set (MDS) dated 1/18/16, indicated R185 had no cognitive impairment and required one person assist with bed mobility, transferring and toileting. R185's medical record revealed on 1/29/16, R185 had sustained a fall while self-transferring from the wheelchair to the toilet. The root cause of the fall identified on the IDT Root Cause Review form dated 2/1/16, was R185's foot had fallen asleep and that her multiple scleroses (MS) diagnosis had affected R185's foot. R185 was sent to the emergency room for evaluation which determined R185 had suffered a fracture of her right distal fibula (ankle) and R185 had been placed on non-weight bearing restrictions on the right foot. R185's care plan dated 12/11/15, indicated R185's diagnoses included weakness, MS, paralytic gait (a gait deficient noted with leg weakness), and second degree burns on the left foot. The care plan also indicated a focus area for safety due to R185's limited mobility related to MS. The care plan interventions directed staff to assure there was a nonslip mat in R185's bathroom and R185 should wear nonskid footwear. However, R185's care plan lacked indication of R185's non weight bearing status on the right due to the recent fractured right ankle nor provided directive on which assistive transferring device should be used.	F 280	negative outcome. Education to nursing staff has been provided to re-educate when care plan updates are needed. Care plan Audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 280	Continued From page 32 R185's nursing assistant (NA) care guide dated 2/3/16, indicated R185 was independent with transfers and lacked indication of R185's non weight bearing status on the right foot. On 2/3/16, at 1:51 p.m. registered nurse (RN)-B confirmed R185's care plan had not been revised to include the non-weight bearing status and the need to provide additional assistance with transfers. On 2/3/16, from 3:26 p.m. to 3:50 p.m. NA-J and NA-N were interviewed and both stated they were aware of R185's non weight bearing status and stated a sit to stand lift was utilized when R185 needed to be transferred. At the same time, NA-K, NA-L, NA-M and NA-O stated they were not aware of R185's weight bearing status and stated they would follow the direction provided on their care guide (which indicated R185 independently transferred). On 2/4/16, at 8:46 a.m. the director of nursing (DON) confirmed R185's care plan should have been revised to include her non-weight bearing status to promote safe care. The Care Plan-Comprehensive policy dated 4/1/08, directed staff to periodically revise the care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		3/21/16

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F 282	Continued From page 33 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written care plan for 1 of 3 residents (R183) who required every one hour repositioning assistance and was observed to not recieve the assistance. Findings include: R183 was not provided every one hour repositioning assistance as directed by the care plan. R183's care plan dated 12/17/15, indicated R183 was at high risk for pressure ulcer/skin issues related to impaired mobility, dementia, weakness and incontinence. In addition, the care plan indicated R183 had a stage 2 (outer layer of skin and part of the underlying layer of skin is damaged or lost. The wound may be shallow and pinkish or red, a fluid-filled blister or a ruptured blister) to his left heel upon admission to the facility. On 1/18/16, an open pressure sore on R183's left heel and an intact blister on right heel were added to the care plan. An open sore on coccyx/sacral (tailbone) was also added to the care plan with no date of this addition.	F 282	Resident 183 care plan has been reviewed and updated to reflect residents current turning and repositioning schedule. Nursing staff re-education regarding following plan of care and interventions for pressure ulcers has been completed. All residents needing assistance in repositioning have the potential to be effected, but none show any negative outcome. Observational audits of turning and repositioning will be completed 3 times weekly X 3 month and then re-evaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 282	Continued From page 34 Interventions directed staff to administer treatments as ordered, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing daily, pressure relieving wheelchair cushion and mattress, elevate heels off bed with pillows at all times and heel protectors on while in bed. On 1/18/16, the intervention to turn and reposition every one hour when in bed was added. R183's nursing assistant care guide directed staff to assist R183 with bed mobility and all activities of daily living, apply heel protectors and keep heels elevated off the bed and reposition every 1 hour. On 2/3/16, from 7:05 a.m. until 9:08 a.m. continuous observations revealed the following: -At 7:05 a.m. R183 was observed laying in bed, positioned on his right side. -At 7:33 a.m. nursing assistant (NA)-I entered R183's room with a sit to stand lift and gathered towels and morning care supplies. R183 stated he was thirsty and NA-I obtained a fresh cold glass of water and after raising the head of the bed up slightly handed the glass to R183 which he drank. R183 remained on his right side. NA-I offered to wash R183 up and get him up out of bed. R183 refused at this time. NA-I tidied up R183's room, took out the garbage and dirty laundry, placed call light within R183's reach and prior to exiting R183's room, NA-I washed her hands. -At 7:50 a.m. NA-I exited R183's room. R183 remained positioned on his right side. During this encounter NA-I had not offered R183 to have his brief checked, toileted or repositioned.	F 282		

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F 282	Continued From page 35 -At 7:55 a.m. licensed practical nurse (LPN)-D entered room and assisted R183's roommate and exited the room. -At 8:25 a.m. the director of nursing (DON) poked her head in the doorway and stated she was just checking on the residents. -At 9:08 a.m. (two hours and three minutes without being repositioned) NA-I and LPN-D entered R183's room, moved R183 up in bed, rolled him from side to side and checked and changed his incontinent brief, assured R183's blue foam boots remained in position on both heels and placed a pillow under R183's feet then exited the room. On 2/3/16, at 9:19 a.m. NA-I confirmed R183's care guide directed staff to reposition him every one hour. NA-I verified R183 went longer than one hour before being repositioned. On 2/3/16, at 9:54 a.m. RN-B confirmed R183 should have been repositioned every one hour and both R183's care plan and care guide directed staff to reposition R183 every one hour. RN-B stated once R183 acquired the sacral pressure ulcer the care plan had been changed from an every two hour to an every one hour turning/repositioning schedule. RN-B stated it was her expectation R183 would be repositioned every one hour and that waiting over two hours was too long. RN-B confirmed R183 was at risk for the development of pressure ulcers. On 2/4/16, at 8:41 a.m. the DON confirmed it was her expectation for staff to follow R183's care plan with regards to pressure ulcer care which included the every one hour turning and repositioning schedule.	F 282		

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F 282	Continued From page 36 Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated the facility had in place a system for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. In addition, appropriate turning and repositioning schedules would be put in place and the care plan updated. Residents who have a loss of skin integrity would receive the appropriate treatments/services which included a repositioning or off-loading plan. Also all interventions and treatments should be evaluated for efficacy and modified/changes as needed. Care plans should be revised if there was a lack of progress towards healing or when a resident acquired a new ulcer.	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 interview and document review, the facility failed to perform neurological assessments following a fall as directed by facility policy for 1 of 1 resident (R180) who had fallen and sustained head and neck injuries and required neurological checks.	F 309	Resident 180 has been re-assessed for falls. Education has been provided to nursing staff of neurological check policy . All residents who are at risk for falls have the potential to be affected, but none show any negative outcome. Neurological audits will be completed	3/21/16

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F 309	Continued From page 37 Findings include: On 2/2/16, at 11:35 a.m. registered nurse (RN)-A stated R180 had sustained a fall the morning of 2/2/16, resulting in a large goose egg on her forehead. The incident report dated 2/2/16, at 8:00 a.m. indicated a staff member had witnessed R180 ambulating independently in the hallway. R180's brief began to fall down, R180 attempted to bend over, pull up the brief and fell forward onto her face. The report indicated R180 sustained a bruised and swollen forehead. A cold compress was applied. The Falls Risk Post Falls Assessment dated 2/2/16, indicated R180 had a history of dementia and was occasionally able to communicate her needs. She did not have any changes in her pain status, nor had R180 expressed symptoms of depression or been recently hospitalized. The interventions to be implemented as a result of the assessment included R180 was to utilize a pullup (underwear style) incontinent product was sent to the emergency room for further evaluation. R180's Nurse's Record and Progress notes revealed the following information: - 2/2/16, at 9:30 a.m. indicated R180 had fallen while ambulating independently in the hallway. R180's incontinent brief slid down, causing R180 to fall hitting her head. R180 was evaluated / examined by the nurse practitioner.	F 309	weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 309	Continued From page 38 - 2/2/16, at 12:30 p.m. indicated R180's bruise spread to the full front of her forehead and down past eyes and right eye becoming almost completely shut. The nurse practitioner was contacted and directed R180 to be evaluated in the emergency room. - On 2/2/16, at 2:40 p.m. R180 was transferred to the emergency room via ambulance. - On 2/2/16, at 7:00 p.m. the emergency room nurse had called the facility and informed them R180 had sustained nondisplaced fractures in cervical vertebra of C1 and C2. R180 was to utilize a Miami J Collar (neck brace) on at all times and was to follow up with neurology appointment in one week. - On 2/2/16, at 8:10 p.m. R180 returned from the emergency room wearing a Miami J collar which was recommended to be on at all times. "resident keeps taking off her collar and is resistant to keeping it on." R180's Neurological Assessment Flowsheet initiated 2/2/16, at 8:15 a.m. revealed neurological assessments were completed every hour through 11:15 a.m. An assessment was documented as being completed at 3:15 p.m. however, at this time, R180 was at the emergency room. The remaining every four hour checks were crossed out with "hospital" indicated. The flowsheet also included a staff directive to obtain complete vital signs and neuro assessments to be performed every hour for four hours then every 4 hours for 24 hours post incident with head injury. R180's medical record lacked further neuro or vital sign assessments between the hours of 3:15 p.m. on	F 309		

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F 309	Continued From page 39 2/2/16 through 6:00 a.m. on 2/3/16. R180's medical record indicated R180 returned from the hospital emergency room at 8:10 p.m. however, the record lacked notation of R180's cognitive status, behaviors, pain or condition upon returning from the hospital with a newly diagnosed neck fracture and head injury. A second Neurological Assessment Flowsheet was initiated on 2/3/16, at 6:00 a.m. and revealed every two hour vital sign / neuro assessments were obtained. On 2/3/16, at 11:48 a.m. licensed practical nurse (LPN)-A verified R180 had sustained a fall with injuries and she would be completing neuro checks on R180 and would offer R180 pain medication. She stated R180 had been resistive with cares and the staff were to follow R180's desires. On 2/3/16, at 12:40 p.m. RN-A confirmed R180's neuro assessments or vital signs had not been competed between the hours of 7:15 p.m. on 2/2/16 and 6:00 a.m. 2/3/16, following the fall with injuries. RN-A stated it was facility protocol to complete neurological examinations every hour for the first five hours and every four hours for 24 hours following a fall. RN-A verified R180's medical record lacked documentation related to R180's condition between 8:10 p.m. to the present time. She stated she had re-started neurological examinations at 6:00 a.m. this morning when she had identified the neurological	F 309		

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F 309	Continued From page 40 examinations had not been completed. On 2/3/16, at 1:53 p.m. the director of nursing (DON) reviewed R180's record and confirmed the record lacked documentation of the completion of neuro checks / vital signs or a nurses notes regarding R180's condition upon her return from the emergency room. The DON verified the last notation in R180's medical record from 2/2/16, indicated R180 had returned from the emergency room with a cervical neck non displaced fracture as well as facial bruising. The Accidents/Fall policy dated 4/1/08, and updated on 2/2014, directed staff to provide emergency care and complete neurological observations following any incident of a resident suspected of hitting their head. The staff were to investigate the incident to determine the cause of the episode, complete post fall assessments, update the resident care plan and to complete continued follow up charting for 72 hours to assess for possible injuries as well as to futher evaluate the interventions put into place. The facility's Neurological Observations policy dated 4/1/08, directed staff to perform neurological examinations every 15 minutes for one hour, followed by every 30 minutes for one hour, followed by every hour for two hours then once a shift for 72 hours or as directed by the physician.	F 309		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	F 310		3/21/16

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F 310	Continued From page 41 Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to re-evaluate a resident's ambulation ability after a decline in ambulation was identified for 1 of 3 residents (R156) in the sample. The resident's decline in ability to ambulate resulted in actual harm. Findings include: R156's admission MDS dated 9/10/15, indicated R156 was diagnosed with cancer, a stroke and tremors. The MDS also indicated R156 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, transfer and ambulation in his room and the corridor. The MDS also indicated R156 was unsteady with transitions and ambulation and required staff assistance to stabilize. R156 utilized a wheelchair for mobility, had no functional limitation in range of motion impairment and R156 and staff believed R156 was capable of increased independence in at least some of the activities of daily living. R156's quarterly MDS dated 12/4/15, indicated R156 required extensive assistance with two staff	F 310	Resident 156 has been referred back to Physical Therapy (PT). All resident on an ambulation program has been reassessed and referred to PT if necessary. All resident that show a change in ambulation status have the potential to be affected, but none show any negative outcome. All residents who are on an ambulatory program who are either not participating or showing signs of inability to perform the program will be referred back to therapy for evaluation. Ambulation audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 310	Continued From page 42	F 310		

for bed mobility, transfers, R156 did not walk in his room or corridor, utilized a walker and wheelchair for mobility and had no functional limitations in range of motion impairment.

R156's discharge summary from a previous facility dated 9/2/15, indicated R156 was able to transfer and ambulate short distances. He had the ability to use a wheelchair and did not attempt to self -transfer.

R156's Nurse's Record and Progress Notes (NRPN) dated 9/15/15, indicated R156 was independently ambulating, staff gave R156 walker and followed R156 with the wheelchair. R156 ambulated to the dining room.

R156's care plan dated 9/23/15, directed staff to ambulate R156 with extensive assistance of two staff, as needed. The plan also indicated R156 displayed physical aggression and exiting seeking behaviors and was not easily directed. Staff were directed to redirect R156 as able, encourage activities of choice and 1:1 conversation. The plan indicated R156 was to remain on the secured dementia unit.

R156's Nursing Rehab program / Functional Maintenance program form, established by physical therapy to be implemented following the discontinuation of physical therapy, dated 10/5/15, and to begin on 10/6/15, directed the nursing assistants to please ambulate R156 one time per day, five days a week using a front wheeled walker with a wheelchair to follow 100 plus feet with minimal assist of one staff for steering the walker as resident pushes walker to the right. R156's goal of the program was to maintain ability to ambulate at least 100 feet daily

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with staff. The form directed staff to report resident status to the physical therapist.

R156's Physical Therapy Discharge Summary dated 10/8/15, indicated R156 had received therapy for increasing functional ability, increasing independence and increase lower extremity strength by the use of therapeutic exercises from 9/4/15-10/8/15. The discharge summary indicated R156 required minimal staff assistance to ambulate on level surfaces, had decreased gait ability and generalized weakness.

R156's NRPN dated 11/3/15, indicated R156 ' s walking program was reduced due to lack of resident participation. R156 was to be ambulated 25 feet three times a week.

R156's NRPN dated 11/11/15, indicated R156 had refused ambulation program regularly. R156's ambulation program was discontinued, however, staff directed to ambulate R156 if he became anxious or attempted to stand several times. Staff to continue to attempt to walk R156.

R156's NRPN dated 12/10/15, indicated walking program initiated but discontinued due to lack of resident participation. Staff to walk R156 with extensive assist of two as R156 allowed. R156 ' s NRPN ' s revealed aggressive behaviors during the provision of cares but did not address / specify aggressive resistive behaviors related to ambulation services.

R156's ambulation program documentation revealed the following information:

-October 2015, Restorative Nursing documentation form directed staff to ambulate

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R156 with two staff 100 feet or more five times per week. The dates of 10/1/15, through 10/16/15, were crossed out. From 10/17/15, through 10/31/15, R156 ambulated six times with a distance ranging from 10 to 475 feet. R156 had refused to ambulate three times. The rest of the form was blank.

-The October 2015, Documentation Survey Report revealed staff signatures for walking in the corridor on either the day, evening or night shift but did not indicate whether R156 ambulated or not. The same form also revealed a section related to ambulation in the room which also indicated staff signatures but not if R156 had ambulated or not.

- November 2015, R156 was to ambulate with two staff 25 feet as tolerated. The documentation indicated R156 was offered to ambulate on five different occasions in which R156 refused each time. The rest of the form was blank. The record did not indicate why R156 refused to participate or interventions attempted to promote participation. On 11/11/15, RN-A reviewed the ambulation program and indicated R156 refused to participate. She indicated R156 would become combative with staff when ambulation was attempted. Therefore, RN-A discontinued R156's ambulation program and directed staff to ambulate R156 if he was anxious or attempting to independently stand. There was no documentation related to a status report to physical therapy or re-evaluation by physical therapy.
However, R156 ' s November 2015, Follow Up Question Report indicated on 11/1/15, 11/3/15, 11/7/15 (x2), 11/9/15, 11/12/15, 11/13/15, 11/15/15 (x2), 11/16/15, 11/19/15, 11/21/15, and

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11/27/15, R156 ambulated with extensive assistance, R156 was involved in the activity and staff provided weight bearing support. On 11/23/15, limited assistance only was provided with R156 highly involved in the activity.

- December 2015, R156 was to ambulate with two staff 25 feet, as needed. The documentation indicated R156 ambulated zero feet on 10 different occasions, however the documentation did not indicated if R156 had refused or ambulation was not offered. The rest of the form was blank. There was no written analysis by the RN indicating R156's ambulation was reviewed.

-The January 2016, Documentation Summary Report indicated R156 ambulated with extensive assist six days during the month. Distance was not documented.

-February 2016, no ambulation program documentation was available for review.

On 2/3/16, at 8:00 a.m. R156 was observed in his room, seated in a Rock and Go (reclining / rocking) wheelchair. RN-A was observed to attempt to push R156's wheelchair, however, R156 put his feet on the ground and refused to allow the chair to move. RN-A tipped the chair back enough for R156's feet to come off of the ground and wheeled him into the dining room.

-At 9:30 a.m. nursing assistant (NA)-A was observed to transfer R156 from the wheelchair to the toilet via a standing mechanical lift. R156's knees were shaky but was able to stand and maintain balance while in the lift.

On 2/9/16, at 9:45 a.m. NA-T stated R156 did not

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have the ability to ambulate. She stated R156 was assisted to transfer via a mechanical standing lift.

On 2/9/16, at 9:47 a.m. RN-A stated R156 did not have the ability to ambulate well so the ambulation program was discontinued and was changed to an as needed program and if staff noted R156 was anxious or trying to stand alone they were directed to attempt to walk with him. RN-A stated she had not reassessed R156's walking ability.

On 2/9/16, at 10:00 a.m. RN-A and nurse consultant (NC)-C were interviewed. RN-A stated R156 was not able to ambulate and verified this was a decline in ability. RN-A stated attempting to ambulate R156 would be dangerous for R156 and the staff. When asked if R156 had been re-evaluated by physical therapy or assessed by nursing following the decline in ability to walk, RN-A stated, "no." NC-C stated when therapy discontinued a resident from services and established a therapy program to be transferred to nursing staff to follow, those discharge instructions were just recommendations for care, not a formal directive at the time of discharge. NC-C stated once a resident was in the care of nursing staff, the RN could decide how to care for the resident related to therapy / exercise program needs. NC-C also stated the physical therapist would not be contacted for further evaluation or screening of the resident ' s ambulation ability because the RN was responsible for adjusting resident therapy goals.

On 2/9/16, at 11:00 a.m. physical therapist (PT)-A stated if a resident was refusing to participate in the walking program and had previously received

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therapy services, she would expect nursing staff to consult with physical therapy prior to changing / decreasing a resident's program. PT-A stated this coordination was to ensure the therapist's input and knowledge was included in order to assist the resident in maintaining ambulation abilities. PT-A stated if a resident declined and was no longer able to participate in the restorative or functional maintenance program which had been established at the time of discharge from physical therapy, she would expect the staff to contact her for a re-evaluation / screening. PT-A verified physical therapy was not contacted to re-evaluate R156's decline in ambulation. In addition, PT-A stated when a resident was discharged from physical therapy and the therapist identified a walking program, that program was considered a directive as to how to care for the resident related to walking. PT-A stated the program was a directive not a suggested recommendation.

On 2/9/16, at 11:20 am. the director of therapy stated the unit managers should have been reviewing each residents' therapy program monthly. The director stated if the managers noticed a resident was not participating in the established program, she would expect the therapy department to be contacted so the therapist could be consulted or they could screen the resident to determine if additional therapy services were needed. The therapy director stated the nursing staff should have consulted with physical therapy prior to discontinuing R156's therapy services.

On 2/9/16, at 11:30 a.m. RN-A confirmed R156's ambulation program was established on 10/5/15, by physical therapy following the discontinuation of therapy services and set up a program for

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F 310	Continued From page 48 nursing staff to follow which included R156 was to ambulate 100 feet daily. R156's medical record revealed on 11/11/15, RN-A had reviewed R156's walking program which indicated R156's walking program was an as needed basis only. R156's record lacked documentation / re-assessment as to why the program had been decreased from 100 feet to 25 feet. RN-A stated R156 did not have the ability to ambulate 100 feet and he was not safe to attempt to ambulate. A policy related to ambulation was requested and none was provided.	F 310		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a timely comprehensive assessment following the identification of a stage two pressure ulcer in order to prevent and / or promote the healing of pressure ulcers and failed to provide every one hour turning and repositioning as directed by the care plan for 1 of 3 residents (R183) admitted with intact skin who developed three stage two	F 314	Resident 183 comprehensive assessments have been reviewed and updated. MD/NP have been updated regarding current pressure ulcer status. Treatments reviewed by NP and changed/updated as needed. Care plan and interventions have been reviewed and updated according to assessments and R 183 is receiving care according to plan of	3/21/16

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F 314	Continued From page 49 pressure related ulcers following admission to the facility. This resulted in actual harm to R183. Findings include: R183's Nurses' Admission Notes form indicated R183 was admitted 12/17/15, was independent with bed mobility and was forgetful with repetitive speech. The note directed the reader to refer to R183's skin assessment for status of skin condition. R183's Skin: Admission Skin Examination / Evaluation form dated 12/17/15, indicated R183 had a skin tag on left outer knee, skin was cool, warm and had bilateral pitting ankle/feet edema. The form also indicated R183 had "soft heels." No mention of a pressure ulcer noted. R183's Nurse's Record and Progress Notes (NRPN) dated 12/17/15, titled "Admit" indicated R183 was non-ambulatory and required the use of a mechanical lift for transfers. There was no mention of a pressure related ulcer. R183's NRPN dated 12/17/15, at 10:30 p.m. indicated R183 was alert but very forgetful with repetitive speech and had bilateral pitting edema in the feet and ankles. Elevate feet in bed. No mention of a pressure related ulcer noted. R183's Short Term Care Plan dated 12/17/15, indicated R183 utilized a pressure reducing mattress in bed and pad in wheelchair. The plan directed staff to provide repositioning every two hours in bed and wheelchair, elevate heels off bed with pillows and heel protectors to be worn when in bed.	F 314	care. All residents that are at risk for pressure ulcers have the potential to be affected, but none show any negative outcome. Interventions and plan of care has been reviewed for R183 regarding pressure ulcer. Other residents with pressure ulcers have been reviewed for current treatment, documentation, and care plan interventions. Re-education to nursing staff has been completed on timeliness of comprehensive assessments following the identification of a pressure wound in order to prevent and/or promote the healing of the pressure ulcers. Re-education to nursing staff has been completed to follow the care plan as indicated. Wound rounds to be completed weekly to gather data on wound progress and appropriate interventions. DON/designee to audit weekly ongoing. Wound and turning and repositioning audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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R183's Nursing Home physician visit note dated 12/21/15, indicated R183 was diagnosed with dementia, anemia, arthritis of hip and osteoarthritis / degenerative joint disease. The note indicated under the SKIN section, R183 had actinic (precancerous patch of thick, scaly or crusty skin) changes on the hands and face. No mention of a pressure related ulcer noted.

R183's NRPN dated 12/21/15, indicated R183 was alert and confused, transferred with mechanical lift and one staff assistance required with bed mobility.

R183's Braden Scale (tool used to predict risk for pressure ulcers) dated 12/23/15, revealed a score of 17. The form indicated a resident with a score of 16 or less was to be considered at risk for developing pressure ulcers.

R183's NRPN dated 12/24/15, indicated nursing assistant (NA) found a blister on R183's left outer heel during morning shower. The note indicated the blister measured 2.8 centimeters (cm) X 2.7 cm and was fluid filled.

R183's NRPN dated 12/24/15, at 12:30 p.m. indicated soft boots were ordered for R183 to wear while in bed to prevent further blisters.

R183's NRPN dated 12/24/15, at 10:00 p.m. indicated left outer heel blister dry and intact, blue pillow boots in place at HS (hours of sleep).

R183's admission Minimum Data Set (MDS) dated 12/24/15, with an assessment reference end date of 12/24/15, indicated R183 had severe cognitive impairment and required extensive assistance of two staff with bed mobility and

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toileting, extensive assist of one staff for transferring and personal hygiene. In addition, The MDS indicated R183 had a stage two (partial thickness, loss of skin with a red-pink wound, without dead tissue) pressure ulcer, was at risk for pressure ulcers, utilized a pressure relieving device in the bed and chair, was not on a turning and repositioning schedule and received pressure ulcer care. The MDS did not indicate where the stage two pressure ulcer was located.

R183's Pressure Ulcer Care Area Assessment (CAA) dated 12/28/15, indicated R183 was at risk for the development of a pressure ulcers / skin issue due to dementia and was noted to have a fluid filled blister on 12/24/15. The CAA also indicated R183 was dependent on staff to meet his needs, was frequently incontinent of bladder, always incontinent of bowel, needed reminders to off load (relieving the pressure to an area) and reposition, was to wear blue boots while in bed and utilized a pressure relieving cushion in the wheelchair and bed. In addition, wound care would assess R183's wound weekly. R183's Nutrition Status CAA dated 12/29/15, indicated R183 was found to have a left outer heel blister and nursing to apply soft pillow boots to prevent further blisters.

R183's Tissue Tolerance (Bed) algorithm assessment form (used to determine the skin's ability to withstand pressure without position change) dated 12/28/15, (completed four days following the identification of a stage two ulcer) indicated this assessment tool was to be completed upon admission, annually and with any significant change in status, upon emergence of pressure ulcers and with changes in pressure surfaces. The form indicated R183 was not

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independent in mobility/positioning and directed staff to follow the identified algorithm. The form directed staff to inspect R183's skin after R183 had been in the same position for two hours. The form indicated R183 had skin redness which did not blanch and directed the assessor to re-exam the skin after one hour. The next checked area indicated R183's skin was no longer reddened and to consider care plan directive to reposition R183 every two hours. The form also indicated determination of a positioning schedule should be conducted in conjunction with a Comprehensive Skin Risk Collection Tool, the Braden Assessment, and resident's preferences and were to be included in the analysis.

R183's Comprehensive Skin Risk Data Collection form dated 12/28/15, (completed four days after the identification of a stage two ulcer) indicated R183 preferred to lay supine (on back) in bed and was to be provided offloading every two hours in bed and wheelchair, heels elevated, heel protectors and incontinence cares. In addition, this Data Collection form indicated R183 had a Rest Q pressure relieving mattress on his bed. The note further indicated R183 had "soft heels," with no actual open areas identified and a trace of lower extremity edema. A hand written analysis indicated R183 had cognitive and mobility impairment, was non-ambulatory, utilized mechanical lift for transfers, was dependent on staff for cares, offloading and repositioning, and peri cares were to be provided after each incontinent episode. There was no mention of a pressure related ulcer noted.

R183's Short Term Preventative Skin Care Plan dated 12/28/15, indicated R183 required assistance with repositioning in the bed and chair,

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was unable to walk or transfer without assistance and was incontinent of bowel and bladder. The plan directed staff to change R183's position every two hours, wear heel protectors, elevate heel off of bed and to utilize a pressure relief mattress and wheelchair pad.

R183's 14 day MDS dated 12/31/15, indicated R183 required extensive assist of two staff for bed mobility, extensive assist of one staff for transfers, did not walk in room and walked 1-2 times in the corridor, was at risk for pressure ulcers, had one stage two pressure ulcer which was present on admission (refer to admission skin assessment which indicated R183 skin was intact with soft heels), utilized a pressure reducing device in the bed and chair, was not on a turning and repositioning schedule and received pressure ulcer care.

R183's current comprehensive care plan for Nutritional/Hydration/Dental initiated on 12/18/15, revealed a hand written entry dated 12/24/15, which indicated R183 had an intact left heel blister and indicated R183 was to utilize blue boots on both feet at HS.

R183's current comprehensive care plan indicated a high risk for pressure ulcers / skin issues was initiated on 1/15/16, related to impaired mobility, dementia, weakness and incontinence. The plan indicated R183 was admitted to the facility with a stage 2 pressure ulcer on left heel. A hand written entry dated 1/18/16, indicated R183 had an open pressure sore on left heel and intact blister on right heel. In addition, an undated, hand written entry indicated R183 also had an open sore on the coccyx /sacral area (tail bone). The plan directed staff to

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administer meds / treatments as ordered, assess/record/monitor wound healing during rounds and to assess and document wound healing. The plan further directed staff to reposition / boost up in bed with two assist and use of draw sheet, to turn and reposition at least every two hours or more often as needed, follow facility policies / protocols for the prevention / treatment of skin breakdown, monitor dressing daily, pressure relieving wheelchair cushion and mattress, elevate heels off bed with pillows at all times and heel protectors on while in bed. A hand written updated entry dated 1/18/16, directed staff to turn and reposition R183 every one hour when in bed and keep heels elevated.

R183's 30 day MDS dated 1/14/16, indicated R183 required extensive assist of two staff for bed mobility, extensive assist of one staff for transfers, and did not walk. The MDS also indicated R183 was at risk for pressure ulcers, had one stage two pressure ulcer which was present on admission, R183 utilized a pressure relieving device in the bed and chair, was not on a turning and repositioning schedule and received pressure ulcer care.

R183's wound assessment flow sheets revealed the following on each pressure ulcer:

Sacral pressure ulcer was acquired at the facility with an onset date of 1/20/16. No stage of the ulcer was noted on this form. There were no nurse's note related to the identification of this wound. The measurements of the sacral pressure ulcer were documented as:

-1/21/16, 1.3 cm x 0.7 cm x 0 cm
-1/25/16, 0.5 cm x 0.5 cm x 0 cm

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F 314	Continued From page 55 -1/27/16, 0.5 cm x 0.5 cm x 0 cm -2/3/16, 1.5 cm (an increase of 1 cm from last measurement and an increase of 0.2 cm from when acquired) x 1.2 cm (an increase of 0.7 cm since last measurement and an increase of 0.5 cm from when acquired) -A hand written progress note on the Wound Assessment Flow Sheet dated 1/21/16, indicated new orders written and new mattress ordered. An additional note dated 1/25/16, indicated wound looks same, measurements same. -A hand written progress note dated 1/27/16, indicated NP observed wound and changed treatment. Right heel pressure ulcer was unstageable (wound with full thickness tissue loss in which the base of the ulcer is completely covered with slough (dead tissue or eschar (dry dark scab) in the wound bed) and had been acquired at the facility (unknown date of onset). The measurements of the right heel pressure ulcer were documented as: -1/19/16, 2.5 cm x 2.5 cm x 0 cm -1/27/16, 2.5 cm x 2.5 cm x 0 cm -2/3/16, 2.7 cm (.2 cm larger) x 2.8 (0.3 cm larger) x 0 cm Left heel pressure ulcer was a stage 2 (partial thickness, loss of skin with a red-pink wound, without dead tissue). The admission notes indicated R183 had "soft heels" upon admission to the facility. The onset date of the blister was 12/24/15. The measurements of the left heel pressure ulcer were documented as: -12/31/15, 3.0 cm x 3.0 cm -1/7/16, 3.0 cm x 3.0 cm -1/15/16, 4.0 cm x 4.0 cm	F 314		

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F 314	Continued From page 56 -1/19/15, 4 .0 cm x 3.5 cm x 0 cm -1/24/16, 3.0 cm x 2.0 cm x 0 cm -1/27/16, 2 cm x 2 cm x 0 cm -2/3/16, 2.1 cm x 3 cm x 0 cm -A hand written progress note on the Wound Assessment Flow Sheet indicated on 12/31/15, the fluid was drained from the blister and skin flap debrided. New dressing order obtained, wound bed beefy red, granulation 100%, surrounding skin intact with no signs of infection. A special pressure reducing mattress on bed and staff to elevate heels and ensure heel boots are in place. -A hand written progress note dated 1/15/16, indicated wound measurements are slightly bigger, wound edges macerated and a heavy amount of serosanguinous (serum and blood) drainage. No signs of infection. -A hand written progress note dated 1/19/16, indicated wound looking better, appears to be getting smaller. -A hand written progress noted dated 1/21/16, indicated wound getting smaller. -A hand written note dated 1/27/16, indicated NP debrided wound and changed treatment. A Tissue Tolerance (Bed) algorithm form dated 1/22/16, (completed two days after the identification of the sacral ulcer and three days after the first documentation of the right heel pressure ulcer) indicated this assessment tool was to be completed upon admission, annually and with any significant change in status, upon emergence of pressure ulcers and with changes in pressure surfaces. The form indicated R183 was not independent in mobility/positioning and directed the assessor to inspect R183's skin after R183 had remained in the same position for two hours. The form indicated R183 had no change in	F 314		

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skin discoloration after two hours without repositioning and directed the assessor to reposition R183 and re-exam the skin after R183 had remained in the same position for three hours. The rest of the form was blank. There were no follow up notations indicated. The form also indicated determination of a positioning schedule should be done in conjunction with a Comprehensive Skin Risk Collection Tool, the Braden Assessment, and resident's preferences were to be included in the analysis.

R183's nursing assistant care guide dated February 3rd 2016, directed staff to assist R183 with bed mobility and to reposition R183 every one hour and to ensure R183 had a pressure relieving mattress, heel protectors with heels elevated off the bed with pillows and pressure reducing cushion in the wheelchair.

On 2/3/16, during continuous observations from 7:05 a.m. until 9:08 a.m. the following was observed:

-At 7:05 a.m. R183 was observed lying in bed positioned on his right side.
-At 7:33 a.m. nursing assistant (NA)-I entered R183's room with a sit to stand lift and gathered towels and morning care supplies. R183 stated he was thirsty and NA-I obtained a fresh cold glass of water and after raising the head of the bed up slightly handed the glass to R183 which he drank. R183 remained on his right side. NA-I offered to wash R183 up and get him up out of bed. R183 refused at this time. NA-I tidied up R183's room, took out the garbage and dirty laundry, placed call light within R183's reach, washed her hands and at 7:50 a.m. exited the room. R183 remained positioned on his right side.

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During this encounter NA-I had not offered R183 to have his brief checked, toileted or repositioned. Nor where the risks and benefits of not being repositioned explained to R183.
-At 7:55 a.m. licensed practical nurse (LPN)-D entered room and assisted R183's roommate
-At 8:25 a.m. the director of nursing (DON) poked her head in the doorway and stated she was just checking on the residents.
-At 9:08 a.m. (two hours and 3 minutes without being repositioned) NA-I and LPN-D entered R183's room, moved R183 up in bed, rolled him from side to side and checked his brief (which was dry), applied a new brief, assured R183's blue foam boots remained in position on both heels and placed a pillow under R183's feet and then exited the room.

On 2/3/16, at 10:56 a.m. LPN-D, nurse practitioner (NP)-A and registered nurse (RN)-B were observed to provide wound care and obtain measurements of R183's three active pressure ulcers. They confirmed the current measurements of R183's three existing pressure ulcers were:

-Right heel pressure ulcer - 2.7 centimeters (cm) in length by 2.8 cm in width by 0 cm depth
-Left heel pressure ulcer - 2.1 cm by 3.0 cm x 0 cm
-Sacral pressure ulcer - 1.5 cm x 1.2 cm x 0 cm

A Tissue Tolerance (Bed) algorithm assessment form completed during the survey on 2/3/16, indicated this assessment tool was to be completed upon admission, annually and with any significant change in status, upon emergence of pressure ulcers and with changes in pressure surfaces. The form directed the assessor to

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inspect R183's skin after R183 had remained in the same position for two hours. The form indicated R183 had skin redness present but was blanchable and directed the assessor to reposition R183 and re-exam the skin after R183 had been in the same position for three hours. The documentation missed a step in the algorithm procedure with the next identified area indicating R183's skin had redness and to consider to care plan directive to reposition R183 every three hours. The form also indicated determination of a positioning schedule should be done in conjunction with a Comprehensive Skin Risk Collection Tool, the Braden Assessment, and resident's preferences were to be included in the analysis.

On 2/3/16, at 9:19 a.m. NA-I confirmed according to R183's care guide he should be repositioned every one hour and verified R183 was not repositioned hourly and had went longer than one hour before being repositioned.

On 2/3/16, at 9:54 a.m. RN-B confirmed R183 was at risk for the development of pressure ulcers and verified R183 was to be repositioned every one hour also and verified both R183's care plan and care guide directed staff to reposition R183 every one hour. RN-B verified R183 had three current pressure ulcers. RN-B stated once R183 acquired the sacral pressure ulcer, the care plan had been changed from an every two hour to an every one hour turning / repositioning schedule. RN-B stated it was "absolutely" her expectation that R183 be repositioned every one hour and that waiting over two hours to reposition, was too long. RN-B confirmed R183's skin assessment had not been re-evaluated after the acquired pressure ulcers had been identified and

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normally RN-B would expect for this to be done. On 2/3/16, at 6:31 p.m. RN-B confirmed R183's sacral wound measurement from today (2/3/16) indicated R183's wound had worsened and was even larger in size then what it was when it was first acquired. At the same time, the director of nursing (DON) also confirmed R183 was to be repositioned every hour which was implemented when R183's sacral wound was identified. The DON also stated waiting two hours to be repositioned was too long for R183.

On 2/4/16, at 8:41 a.m. the DON confirmed it was her expectation for staff to follow R183's care plan with regards to pressure ulcer care which included the every one hour turning and repositioning schedule.

On 2/5/16, at 11:18 a.m. NP-A verified R183's sacral wound was a stage 2 pressure ulcer.

Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated the facility had in place a system for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. The policy indicated a "head to toe" skin assessment would be completed on admission or within 24 hours of admission and a Tissue Tolerance test (both lying and sitting) and a Braden skin assessment would also be conducted within 24 hours of admission. All residents' were preventatively placed on a pressure reduction mattress and cushion in the wheelchair based on the skin assessment and an appropriate turning and repositioning schedule would be put in place and the care plan updated. Residents who have a loss of skin integrity would receive the appropriate treatments/services which included a repositioning or off-loading plan. Also

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F 314	Continued From page 61 all interventions and treatments should be evaluated for efficacy and modified/changes as needed. Care plans should be revised if there was a lack of progress towards healing or when a resident acquired a new ulcer.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct ongoing comprehensive fall assessments to determine causal factors for 1 of 1 resident (R180) with a history of falls and continued pattern of self transfers and ambulation. This failure resulted in an immediate jeopardy (IJ) due to R180 sustaining cervical (neck) fractures as a result of a fall on 2/2/16. In addition, the facility failed to implement their smoking policy related to safe smoking practices and / or the safe storage of tobacco products and fire materials for 2 of 2 residents (R136, R95) observed to have their smoking and fire materials unsecured or unsafely extinguishing / disposing of the cigarettes. Findings include: The immediate jeopardy related to falls began on	F 323	Resident 180 has been re-assessed for fall risk and care plan has been updated to include pressure alarm in bed and wheelchair to alert staff when she is attempting independent ambulation. Comprehensive fall assessment has been completed for R180 causal factors for fall risk have been identified. Care plan has been updated according to the assessment. R180 is receiving care according to the plan. Ongoing monitoring and follow up regarding injury related to the fall. Staff educated regarding updates of the care plan completed. Education with nursing staff regarding comprehensive fall assessments has been completed to include reviewing interventions if the resident has a change	3/21/16

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F 323	Continued From page 62 October 15th, 2015, when the facility assessed R180 to have increased from a low risk for falls to a high risk for falls due to R180's increased mobility and unsafe independent transfers / ambulation and failed to assess for causal factions related to R180's independent mobility in order to prevent and / or minimize falls, injury and / or death. The administrator and the director of nursing (DON) were notified on 2/3/16, at 7:25 p.m. of the IJ. The IJ was removed on 2/5/16, at 2:05 p.m., however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R180 due to a neck fracture sustained during a fall which required medical interventions. R180 was identified as high risk for falls related to cognitive impairment, impaired gait and mobility, history of falls and unpredictable behaviors. However, the facility failed to comprehensively assess R180's risk factors related to falls which would include possible causal factors related to attempts at unsafe independent transfers. R180's Essentia Health Interagency Referral Form dated 4/23/15, completed prior to admission, indicated R180 received hospice services related to end stage dementia and sepsis. The form also indicated R180 was impulsive, had poor safety awareness, poor attention/concentration, limited left lower extremity movement, and serious difficulty with walking and had sustained a fall. R180 had a right arm hematoma (bruise) and a skin tear to the left arm. The activity instructions directed staff to ambulate with one staff assistance and walker.	F 323	in fall risk category that will need new interventions. Audit all resident fall assessments for changes in fall risk category to determine if new interventions are needed. Residents R136 was reviewed for smoking safety intervention and care plan was updated as indicated. Resident 95 no longer resides at facility. Smoking policy revised and approved through Ad HOC QA. New smoking policy reviewed with smoking residents and for all new admissions. All residents that smoke have had a new smoking assessment completed, new smoking care plans in accordance with the assessment completed. Education with staff regarding smoking policy and expectations has been completed. All resident with falls that need neurological checks have the potential to be affected, but none show any negative outcome. All smoking residents may be affected by the new policy for smoking and assessment of storage to their smoking material. Neurological and smoking audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 323	Continued From page 63 R180's Falls Risk Assessment (admission) dated 4/29/15, indicated R180 had impaired cognition, 3 or more falls in the last 6 months, mobility was weak and unsteady and utilized a wheelchair for mobility. The written summary indicated R180 was at risk for falls due to unsteady gait and R180's lack of safety awareness. A nurse progress note dated 4/29/15, indicated R180 stood and walked down the hallway independently for several feet and was slightly unsteady. A follow up note dated 4/29/15, indicated the resident was up in the wheelchair and got out of the wheelchair once, and the, "alarm sounded." There was no corresponding assessment indicating the resident had an alarm on the wheelchair. A nurse progress note dated 5/22/15, indicated R180 had removed the safety alarm and was up and ambulating independently. Staff ambulated R180 and attempted to seat her back in her wheelchair. R180's care plan printed on 5/13/15, indicated R180 had advanced dementia with falls and anxiety, was admitted with bruises to the left knee, right hand, left hip, red area and superficial open area behind right knee and skin tear to left hand. R180 was to reside on the locked dementia unit due to dementia / delirium, was not able to use the call light, was frequently incontinent of bladder, and required two staff extensive assistance to toilet and ambulate. The care plan directed staff to keep the call light within reach with reminders to use it to call for staff	F 323		

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F 323	Continued From page 64 assistance, to utilize a PSD (personal safety device), non-skid footwear, do not leave unattended in the bathroom, required two staff assist for transfers and bed mobility, and required extensive assist with wheelchair locomotion. R180's Fall Risk Assessment quarterly review note dated 8/4/15, indicated R180 was at low risk for falls due to resident compliance with chair fast ability, and resident choice not to attempt to independently ambulate 90% of the time. The update indicated the directive was to continue with current plan of care. However, R180's attempts to independently ambulate was not assessed, nor interventions developed or implemented related to R180 independently ambulating. R180's care plan printed on 8/13/15, indicated R180 was at risk for falls R180 was at risk for falls due to being in a new facility, end of life care, dementia, and had a history of falls. The plan directed staff to ensure R180's environment was free of clutter, keep commonly used articles within easy reach, and fall review per facility protocol, had advanced dementia with falls and anxiety, was non ambulatory, was unable to use the call light, required two staff assistance for bed mobility, one assist for transfers, utilized the wheelchair for locomotion, was incontinent of bladder, and utilized an incontinent brief. A hand written entry on the care plan dated 8/25/15, directed staff to use a communication board to ask R180 if she needed to use the bathroom, desired to go to bed, was hungry, thirsty or in pain.	F 323		

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F 323	Continued From page 65 A Resident Incident Report dated 8/23/15, at 1:15 p.m. indicated at 1:10 p.m. an unidentified nursing assistant (NA) was in R180's room and found R180 to have been incontinent of urine with soiled linens. The NA briefly stepped out the room to gather supplies and additional assistance. Upon re-entering the room at 1:15 p.m., R180 was found lying on the floor between the bed and the radiator. R180 was noted to have two cuts to the outside of the right eye measuring 0.8 centimeters (cm) by 0.1 cm and 0.3 cm by 0.1 cm., a skin tear to the lower right arm which measured 5.0 cm by 4.2 cm, and also had a bump on the forehead which measured 2.3 cm by 4.0 cm.. The RN supervisor reviewed the report on 8/23/15, indicated R180 was incontinent of bladder and the resident's bed was wet, therefore the NA had left the room to gather fresh linens and upon returning to the room, R180 was found on the floor. The fall investigation / assessment completed at the time, did not identify assessments or alternative interventions implemented at the time of the fall to minimize the risk for further falls from bed. Nor did the investigation include documentation of consideration of any further safety interventions that could be utilized when R180 attempted to get out of bed unassisted. R180's significant change Minimum Data Set (MDS) dated 10/14/15, which was completed due to discontinuation of hospice services, indicated R180 had severe cognitive impairment, displayed physical resistance to cares, required extensive assistance of two staff for ambulation, transfers and bed mobility. The MDS also indicated R180 had unsteady balance during transitioning and	F 323		

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walking, and required staff assistance to stabilize. R180 had sustained one fall with injury during the MDS assessment period.

R180's Falls Care Area Assessment (CAA) dated 10/20/15, indicated R180 was at risk for falls, fractures, and soft tissue injuries.

R180's Falls Risk Assessment form dated 10/15/15, indicated R180 had sustained 1-3 falls in three months, had unsteady mobility, utilized a wheelchair, had dementia, was incontinent of bowel and bladder, was sometimes able to communicate her needs, required staff assistance for transfers and was unable to use the call light. The written summary indicated R180 was at greater risk for falls due to cognition impairment, lack of safety awareness, and the resident attempted to walk independently. Although R180 was identified as going from low risk of falls on 8/4/15, to higher risk on 10/15/15, and continued to self transfer but was unsteady, the assessment lacked documentation of any further assessment to determine if any additional interventions were required to ensure resident safety such as causal factors related to self rising due to her lack of safety awareness.

R180's Communication CAA dated 10/20/15, indicated R180 was diagnosed with advanced dementia. The CAA also indicated R180 had a fall on 8/23/15, with a minor injury and on 6/20/15, also with minor injury (an incident report or documentation related this fall was not provided). R180 was not to be left unattended in the bathroom and wore non-skid footwear, and

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required extensive assist of one staff with all ADLs. The CAA also indicated R180 had diminished ability to express emotions and decreased ability to listen to others and share information.

A Resident Incident Report completed on 12/2/15, indicated R180 was found with bruises which measured 4.0 cm x 4.5 cm in the middle of the back, and a left hip bruise which measured 7.0 cm x 7.0 cm. R180 was unable to state how the bruises occurred. The nurse investigation indicated, "Res [resident] may have very well fallen and may have gotten up independently." Further, the form indicated R180 had become more ambulatory and would be beginning physical therapy. However, the report lacked documentation of any further assessment of causal factors or environmental factors to determine interventions to be implemented to ensure R180's safety.

R180's Physical Therapy Discharge Summary Recommendations dated 12/17/15, indicated R180 was referred to physical therapy (PT) for a walking assessment. The discharge diagnosis indicated R180 had difficulty walking, weakness, and lack of coordination. The PT recommendation form included a directive for a nursing ambulation program which consisted of hand hold assistance during ambulation, otherwise the resident was to utilize a wheelchair.

R180's quarterly MDS dated 1/7/16, indicated R180 was diagnosed with Alzheimer's dementia and delirium superimposed on dementia. The

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F 323	Continued From page 68 MDS indicated R180 required extensive assistance of one staff with bed mobility and transfers, required extensive assist of two staff for ambulation in her room, and limited assist of two staff for ambulation in the corridor. The MDS also indicated R180 had unsteady balance during transitioning and walking and required staff assistance to stabilize. The MDS indicated R180 displayed wandering behaviors and R180 had not sustained a fall during the MDS assessment period. R180's Falls Risk Assessment quarterly review dated 1/14/16, indicated R180 was at risk for falls, had no safety awareness and attempted to independently ambulate. Staff were to walk with R180 using a gait belt and a wheelchair. However, R180 continued self transfer attempts and interventions related to self-ambulation attempts / monitoring for self-ambulation were not identified. R180's care plan printed on 1/19/16, indicated R180 had advanced dementia with falls and anxiety, was at risk for falls due to dementia and history of falls, was unable to use the call light, was incontinent of bladder, required extensive assist of one to two staff for ambulation and gait belt, extensive assist of one to two staff to boost up in bed, extensive assist of one staff to toilet, staff utilized a dry erase board for communication, extensive assist of one staff for transfers and wheelchair assistance for greater distances otherwise independent for shorter distances while in the wheelchair, and to allow R180 to sleep in.	F 323		

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F 323	Continued From page 69 On 2/2/16, at 11:35 a.m. registered nurse (RN)-A stated R180 had sustained a fall the morning of 2/2/16, resulting in a large goose egg on her forehead. A Resident Incident Report dated 2/2/16, indicated at 8:00 a.m. a staff member had witnessed R180 ambulating independently in the hallway. R180's incontinent brief began to fall down, R180 attempted to pull up the brief and fell forward onto her face. R180 had sustained a bruised and swollen forehead. A cold compress was applied. The RN supervisor note dated 2/3/16, (unable to determine if dated 2/2 or 2/3), indicated a pull up (underwear style) incontinent product was to be used. The Falls Risk Post Falls Assessment dated 2/2/16, indicated R180 had dementia and was last seen in bed prior to the fall. The assessment indicated R180 was occasionally able to communicate her needs, did not have any changes in her pain status, nor had expressed symptoms of depression or been recently hospitalized. The interventions to be implemented following this fall was to change R180's incontinent brief to a pull up style incontinent product and R180 was sent to the emergency room (ER) for evaluation. Although the form indicated R180 was last seen in bed prior to the fall, there was no assessment of R180's continued attempts to self transfer, increased mobility status, nor did the facility reassess R180's safety while self transferring / rising from bed to ensure no further interventions were needed.	F 323		

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The Root Cause analysis form indicated the nurse manager and DON had met on 2/3/16, at 6:45 a.m. to discuss R180's 2/2/16, fall. The form also indicated the interdisciplinary team (IDT) also discussed this fall on 2/2, 2/3, and 2/4/16. The documentation indicated interventions in place at the time of the fall were to ensure R180's environment was free from clutter, commonly used items placed within reach and laminate or dry erase board utilized for communication. About an hour prior to the fall, staff had observed R180 in bed sleeping. Causal factors reviewed indicated R180 was independently ambulating and the incontinent brief she was wearing was hanging down and sliding to the floor (witnessed fall). The root cause of the fall was determined to be R180's brief was too large causing it to slip down and R180 bent down to pull up and fell forward. However, the root cause analysis only documents what occurred but fails to comprehensively assess the resident's risk factors including R180's pattern of self transferring and other factors to attempt to minimize further falls or injury for R180 and failed to identify why R180 had been ambulating independently prior to the fall. The documentation indicated new interventions put in place on 2/2/16, were staff to utilize a pull up incontinent product and on 2/3/16, following the fall review, staff were encouraged the use of a neck collar for comfort and a pharmacy review would be performed, however, there was no indication when this would be completed. Although R180 sustained significant injury, her mobility had increased, she had last been seen in bed, there was no corresponding assessment to determine if these risk factors required further safety interventions to be in place related to self rising

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F 323	Continued From page 71 from bed and independent ambulation. The care plan printed on 1/19/16, included hand written entries dated 2/2/16, indicated R180 was to utilize a pull up incontinent product and bladder scan daily. A hand written entry dated 2/5/16, indicated R180 was to utilize a pressure alarm in bed, use a wheelchair, and 15 minutes checks were initiated to monitor for impulsivity. However, observations/interviews indicated the pull up intervention was not consistently implemented. During a follow up interview on 2/3/15, at 10:10 a.m. RN-A confirmed R180 had a sustained neck fracture during the fall on 2/2/16. On 2/3/16, at 7:34 a.m. R180 was observed resting in a low bed. R180's eyes are completely blackened with bruising. On 2/3/16, at 11:42 a.m. NA-B stated he was not aware of any new concerns or new interventions implemented for R180. On 2/3/16, at 11:43 a.m. R180 was observed in her room, in bed. On 2/3/16, at 11:44 a.m. NA-C stated he had been informed R180 had fallen on 2/2/16, and had been diagnosed with "something" but was not sure what. NA-A stated he was not aware of any changes made to R180's care plan following the fall on 2/2/16, and stated he was just to monitor R180.	F 323		

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F 323	Continued From page 72 On 2/3/16, at 12:26 p.m. R180 was wheeled from her room to the dining room. R180 informed her tablemate "I hurt my neck." On 2/3/16, at 12:40 p.m. RN-A stated the facility was to put interventions in place which were to be discussed at the 9:45 a.m. morning meeting, and they were to attempt to find the root cause of R180's fall. RN-A stated the morning meeting had not yet taken place, however, she believed the reason why R180 had fallen was due to R180 self-ambulating and the brief slipping down. RN-A indicated she had changed R180's incontinent product from a brief to a pull up style. On 2/3/16, at 1:00 p.m. NA-A stated R180 had sustained a fall on 2/2/16, and was to wear the neck collar, however, there were no other changes made to R180's plan of care that she was aware of. On 2/3/16, at 1:03 p.m. RN-A confirmed the fracture R180 sustained during the fall, was a significant fracture. She confirmed the new intervention put in place after the fall was to use a pull up and a neck collar was to be used. RN-A did not offer any further interventions to be utilized for R180. On 2/3/16, at 1:43 p.m. the director of nurses (DON) stated the usual facility practice when a resident fell was for the staff to assess the resident, complete an interdisciplinary report,	F 323		

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evaluate the scene and remove any areas of concerns. The staff were then to complete vitals, review the care plan, and evaluate if the care was being implemented correctly. The staff were to bring up the concern at the morning falls committee meeting following the morning interdisciplinary meeting. The DON stated she understood the plan at this time was to ensure R180 wore the neck collar.

On 2/3/16, at 1:53 p.m. the DON reviewed R180's record and confirmed clinical record indicated R180 had returned from the ER with the neck fractures. DON stated the direct care staff should have been made aware of the changes related to the type of incontinent products for R180.

On 2/3/16, at 7:13 p.m. during the provision of cares, R180 was observed to have approximately two inch bruises on both knees.

On 2/4/16, at 10:28 a.m. R180 was observe din the dining room, attending an activity. R180's bruising to the face was noted to be a deep purple color on her face, forehead, both eyes and upper checks.

The Accidents/Fall policy dated 4/1/08, and updated on 2/2014, directed staff to provide emergency care, complete neurological observations (neuro's) following any incident of a resident suspected of hitting their head. The staff were to investigate the incident to determine the cause of the episode, complete post fall assessments, update the resident care plan and to complete continued follow up charting for 72

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hours to assess for possible injuries as well as to further evaluate the interventions put into place.

The IJ that began on 2/2/16, was removed on 2/5/16 at 2:05 p.m. when the facility completed the following interventions which were verified through observation, staff interviews and record review:
-comprehensive fall assessment
- implemented new interventions including a personal alarm system while R180 was in bed or the wheelchair.
-changed R180's incontinence product to a pull up
- the nurse practitioner, R180's primary MD and the medical director along with the consultant pharmacist reviewed R180's medical record. The primary physician ordered R180 to receive a bladder scan daily to rule out urinary retention. Drug regimen review was conducted.
-the nursing assistant care sheets were updated with care plans
- R180 was placed on every 15 minute checks to determine the root cause of R180's impulsivity when standing/ambulating independently
- the facility provided education to all staff members responsible for R180's care.

R133 was a smoker and the staff failed to ensure R133's tobacco products and fire materials were kept secure for the safety of all residents and failed to ensure safe smoking practice was maintained related to R133's putting out the cigarette on her electric wheelchair control panel and placing the butts in her jacket pocket.

On 2/2/2016, at 9:10 a.m. R133 was observed to leave the facility through the main entrance, via

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an electric wheelchair, to smoke. R133 stated the resident smoking shelter was located around the corner to the left of the entrance. However, R133 stated she had been "banned for life" from smoking there. R133 stated licensed social worker (LSW)-A banned her from smoking due to smoking while an oxygen tank was attached to her electric wheelchair which created a safety risk. At this time, an empty oxygen canister storage sleeve was observed attached to the back of R133's electric wheelchair. R133 stated she knew she was not to smoke with her oxygen on or the tank attached to her chair. R133 proceeded down the sidewalk located directly in front of the entrance to a location on the sidewalk at the end of the building. R133 stated she was supposed to smoke across the parking lot but stated she would not go over there because of the snowbank. R133 gestured at a snowbank approximately four feet high which covered the end of the sidewalk. R133 stated she must smoke by herself at the end of the sidewalk. The area R133 smoked at lacked receptacles for the extinguishment of smoking materials. R133 proceeded to light a cigarette with a disposable lighter and smoke it. When asked what she did with the cigarette when she had completed smoking it, R133 stated she stubbed it out on the arm of her electric wheelchair and placed the butt into the pocket of her jacket. R133 again stated she was not allowed near the smoking area where the cigarette receptacle was located so she "snuck over" to that area when no one was there and disposed of her cigarette butts in the receptacle. R133 stated she kept her own smoking supplies in her possession and had a locked drawer in her nightstand where she kept her cigarettes and lighter. R133 proceeded to smoke the cigarette to within approximately 1/4

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inch of the filter, flicked the lit cigarette back and forth several times along the right outer edge of the control panel on the right arm of her electric wheelchair. The control panel was scraped, marred and pock-marked for approximately three inches along the right outer edge where R133 was observed to flick her lit cigarette. R133 stubbed the cigarette vertically onto the upper right surface of the control panel and placed the stubbed cigarette into the left breast pocket of her jacket. The right upper surface of the control panel was observed smudged with white ash. In addition, R133's left corner of her seat cushion was observed to have an approximate 1 inch cut in the upholstery with exposed foam cushion. R133 drove her electric wheelchair to the smoking receptacle (located around the corner on the left side as the building was exited), removed two cigarettes butts from her left breast jacket pocket and disposed of them into the receptacle. R133 stated she kept the butts in her pocket until she was able to dispose of them unseen. R133 further stated she did not have many to throw away at that time as she had emptied her pocket the previous night. R133 entered the building via the main entrance.

R133's Minimum Data Set (MDS) Quarterly Note dated 4/11/15, indicated R133 had cognition that fluctuated due to chronic obstructive pulmonary disease (COPD) and was able to communicate her needs and make her own decisions. R133 was a smoker and was assessed as independent.

R133's quarterly MDS dated 12/20/15, indicated R133 was cognitively intact, had diagnoses that included COPD, respiratory failure, anemia, diabetes, anxiety and received oxygen therapy.

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The MDS also indicated R133 required supervision for bed mobility and transfer, required extensive assist of one for dressing and was independent with locomotion on and off of the unit.

R133's Smoking Safety Assessment (SSA) dated 4/14/15, identified R133's cognition skills for decision-making were independent, indicators of delirium were not present, and R133 had clear speech. The SSA identified R133 used an electric wheelchair as the primary mode of locomotion, had no visual or range of motion limitations and had no disease/diagnosis impacting ability to smoke. The SSA also indicated no devices or restraints were used by R133. The SSA further indicated R133 was able to use an ashtray to self-extinguish a cigarette, could use a lighter safely and had no history of smoking-related incidents. The SSA identified interventions as independent, with no assistive devices needed and indicated R133 was instructed and understood the facility smoking policy. No care plan concerns were identified.

R133's Social Services Progress Note dated 6/18/15, indicated R133 was in violation of smoking policy by being in smoking area with oxygen on which was discussed with R133. R133 was informed of a three day loss of onsite smoking privileges due to this violation. Nursing was informed. The note further indicated following R133's notification of the three day lost privileges, R133 was found by social services in the resident smoke area, smoking. R133's room was searched. All cigarettes and lighters were taken and locked up. Son informed of situation. Son would prefer R133 not smoke at all.

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R133's Quarterly Smoking Safety Review dated 6/18/15, identified a change to the initial smoking assessment to include a three day loss of privilege due to smoking with oxygen and facility storage of tobacco products and fire materials. No Smoking Safety Assessment was completed.

R133's Nurse's Progress Note dated 7/23/15, indicated staff found R133 outside in a non-smoking area smoking with oxygen tank on her chair. RN manager and social worker talked to R133. R133 was informed her smoking privileges were revoked and was no longer to smoke on the premises. However, no Smoking Safety Assessment was completed.

R133's Social Services MDS Annual Note dated 9/28/15, indicated R133 was a smoker and had "bummed cigs" and was aware that is was against the rules. R133 was allowed to smoke off the premises only.

R133's Quarterly Smoking Safety Review dated 9/28/15, identified a change to the initial smoking assessment to include smoking off premises only. No Smoking Safety Assessment was completed.

R133's Care Plan dated 10/19/15, identified a focus area of Mood / Behavior which indicated R133 became shaky and talked fast when anxious due to shortness of breath. R133 was a smoker and lost her privileges to smoke on the premises of the facility due to being seen in a non-smoking area smoking a cigarette with and oxygen tank on her chair. The Care Plan directed staff R133 had signed facility smoking rules/guidelines, had lost her privileges to smoke on the premises of the facility and to remind R133 as necessary. The Care Plan also identified a

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Cognition focus area which indicated R133's cognition fluctuated during the day due to hypoxia. In addition, a Smoking focus area indicated R133 was as smoker and directed staff R133 was an unsafe smoker and was no longer able to smoke on the premises. R133 utilized a flag on the wheelchair when she went outside.

R133's Social Service Progress Note dated 10/22/15, indicated a care conference was held and R133 chose not to attend. The note indicated R133 smoked on the premises outside. No smoking assessment was completed at this time.

R133's Quarterly Smoking Safety Review dated 12/20/15, identified a change to the initial smoking assessment to include smoking off premises only. No Smoking Safety Assessment was completed to determine where R133 smoked off premises as well as how R133 disposed of smoking material.

On 2/3/16, at 12:51 p.m. R133 was observed eating lunch in her own room. R133 stated she had been out smoking several times and was not able to dispose of her cigarette butts at first due to the snow but had since been able to. At this time R133 removed two smoked cigarette butts out of her pocket and showed them to the surveyor.

On 2/3/16, at 3:46 p.m. licensed practical nurse (LPN)-C confirmed R133 was a smoker. LPN-C stated R133 left the oxygen tank in her room when out smoking, but she was not sure what R133 did once she was outside. LPN-C stated there was a smoking shack that other residents could use but she was not sure where R133

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smoked. LPN-C stated she thought R133 was supposed to be 20 feet from the building or in the smoke house but was not sure if R133 was banned from the property. LPN-C stated R133 kept her own smoking materials and she was not sure where R133 kept them. LPN-C was also not sure how often R133 smoked but stated when it was cold outside she had seen her go out about twice per shift.

On 2/3/16, at 3:52 p.m. NA-F stated R133 was independent with her smoking and staff didn't do anything regarding her smoking. NA-F stated R133 went out to smoke a couple of times per day and she usually saw R133 by the end of the building. NA-F confirmed R133 was not allowed to smoke in the smoking shack but stated she was not sure why. NA-F indicated R133 had smoking materials in her room but had no idea where R133 kept them. NA-F also indicated R133 was not supposed to use her oxygen when out to smoke. NA-F stated there had been no problems with R133 smoking that she knew of.

On 2/3/16, at 3:55 p.m. NA-G stated R133 went outside to smoke 4-5 times on her shift. NA-G indicated R133 went out to the main area/smoker's shed or to the end of the sidewalk to smoke. NA-G stated the only responsibility staff had regarding R133's smoking was to remind her to take her oxygen tank off of her wheelchair and use a flag on her wheelchair. NA-G stated she knew of no issues with R133 smoking.

On 2/3/16, at 4:02 p.m. RN-F stated quarterly safety assessments were performed for all smokers. RN-F also stated R133 smoked independently, without supervision and on an

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average shift R133 was out 1-3 times to smoke. RN-F indicated R133 was to smoke at the end of the sidewalk. RN-F indicated R133 was not allowed to smoke in the smoker's shed as she had a history of smoking with an oxygen tank on her chair and was deemed unsafe. RN-F indicated the requirements for R133 to smoke were to take the oxygen tank off of her chair and use a flag on her electric wheelchair. RN-F stated she had no idea where R133's smoking materials were kept but that R133 had them. RN-F stated R133 had not had any problems with burns that she was aware of.

On 2/3/16, at 4:10 p.m. licensed social worker (LSW)-A stated she didn't really have any control of R133's smoking or what she did. LSW-A stated R133's privileges had been taken away due to an incident when R133 was smoking in non-smoking area next to a running diesel truck. LSW-A indicated the physician had been contacted at that time and had discontinued R133's oxygen for a time. The physician had indicated R133 should be allowed to continue to smoke if she desired. LSW-A indicated R133 continued to smoke and they allowed her to smoke off the premises. LSW-A stated she did not know what was done now to keep R133 safe, however, R133 had been good about removing the oxygen tank from her wheelchair now.
-At 4:16 p.m. LSW-B stated he became R133's social worker in 11/2015, and to his knowledge she could smoke on the premises and in the smoking shack as long as her oxygen canister was off of her wheelchair. LSW-B stated there had been no issues related to smoking since he had started working with R133. LSW-A and LSW-B both agreed the practice of R133 placing cigarette butts into her jacket pocket and stubbing

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out her cigarette on the control panel of her chair were not safe practices which put R133 at risk for injury. Both stated they were not aware she had been doing it. LSW-A confirmed the Resident Smoking Agreement required the storage of smoking materials at the nurses' station. However, LSW-A indicated R133 was an "exception to the rule." LSW-A indicated it was agreed R133 could keep her smoking materials in a locked drawer in her room to try to prevent R133 from picking used cigarette butts out of the cans and "bumming" cigarettes and lighters. LSW-A indicated the smoking policy should reflect storage of smoking materials were addressed on a case by case basis.

On 2/3/16, at 4:49 p.m. RN-F confirmed R133's Smoking Safety Assessment completed on 4/14/15, was an annual assessment that included an observational audit. RN-F also confirmed R133's Quarterly Smoking Safety Reviews completed on 6/18/15, 9/28/15 and 12/20/15, were a review of the Resident Smoking Agreement and Resident Smoking Guidelines only and did not include an observation of R133 smoking. RN-F confirmed she had performed the most recent Quarterly Smoking Safety Review on 12/20/15, and at the time of the review, R133 was using a nicotine patch and was not smoking. RN-F stated she had not completed a full smoking assessment or observational audit of smoking for R133, and was unaware of how R133 was extinguishing her cigarettes, and was unaware R133 was placing the cigarette butts into her jacket pocket and not disposing them into a proper receptacle.

On 2/3/16, at 6:27 p.m. R133 stated she had not had any burn holes in her clothing from smoking.

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At this time, one small pin point burn hole was observed on the right front breast area of R133 ' s jacket. When mentioned to R133, she stated the wind had blown ash onto her jacket.

A Smoking Safety Assessment completed during survey on 2/3/16, indicated R133 was independent with smoking, had a history of unsafe smoking practices, was required to follow facility smoking policy and could stay on facility premises to smoke. The form also indicated the facility was to store R133 ' s tobacco products and fire materials.

On 02/05/2016, at 11:27 a.m. the director of nursing (DON) verified R133 had incidents of noncompliance with the smoking agreement that led to her losing smoking privileges. The DON confirmed R133's practice of extinguishing her cigarette utilizing the control panel of her electric wheelchair and placing the butt in her jacket pocket was an unsafe practice.

The Resident Smoking Agreement dated May 14, 2014, indicated all residents who wished to smoke received a smoking assessment and a signed copy of the smoking guidelines. The Agreement also indicated a smoking assessment would be completed, at minimum upon admission, quarterly and with a change in resident condition. The Agreement further indicated any time a resident violated the requirements of the smoking agreement, the resident would be reassessed for smoking.

R95 was a smoker and the staff failed to ensure R95's tobacco products and fire materials were kept secure for the safety of all residents. In addition, the staff lacked knowledge on R95's

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F 323	Continued From page 84 smoking plan. R95's annual MDS dated 1/10/16 indicated R95 was cognitively intact, required supervision off and on the unit, limited assist with personal hygiene, and had current tobacco use. R95's Integrated Problem list, undated, indicated R95 was diagnosed with diabetes mellitus type II, anxiety, depression, dependent personality disorder and tobacco abuse. R95's Smoking Safety Assessment dated 1/13/16, indicated, R95 was able to move without assistance to/from designated smoking areas, able to use ashtray to self-extinguish cigarette, could use lighter or matches safely, had history of smoking related incidents such as burned clothing and indicated R95 was wear a smoking apron. R95 was able to independently smoke with use of smoking apron. R95's Resident Smoking Agreement dated 6/30/15 indicated, all residents who wish to smoke during their stay will receive a smoking assessment and a signed copy of the smoking guidelines. All smoking materials must be kept secure for the safety of all residents. We recognize there are special circumstances and other options will be designed for individual situations, If the smoking assessment demonstrates the resident is able to safely smoke independently, by meeting all of the conditions described in the assessment, the resident's care plan will be revised to include the resident's wishes to smoke. The signed agreement did not identify any special circumstances. R95's Resident Smoking Guidelines dated	F 323		

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6/30/15, indicated, all smoking materials must be kept secure for the safety of all residents. We recognize there are special circumstances and other options will be designed for individual situations, The Guidelines lacked any special circumstances.

On 2/2/16 at 8:24 a.m. R95's over the bed table was observed to contain a tray which contained a 16 ounce bag of loose tobacco, a cigarette rolling machine, 20 filtered cigarettes, a purple cigarette box, 3 cigarette lighters and loose tobacco covering the tray. R95 was not in the facility as had been admitted to the hospital on 1/25/16.

On 02/02/2016, at 1:35 p.m. R95's over the bed table continued to contain the 16 ounce bag of tobacco, a cigarette roller, the purple cigarette box, 20 filtered cigarettes, and three cigarette lighters. A strong tobacco odor was noted in R95's room.

On 2/2/16 at 1:40 p.m. R95 is observed to return from the hospital.

On 2/2/16, at 2:13 p.m. R95 stated she rolls her own cigarettes and she was currently headed to the smoke shack. R95 was observed to put on her jacket, pick up three cigarette lighters and the purple cigarette box and put them into her jacket pocket. R95 stated, she had just returned from the hospital and I am going out to smoke. R95 left the bag of tobacco and cigarette roller, 20 cigarettes and loose tobacco on the over the bed tray.

On 2/2/16, at 7:30 p.m. R95 readmitted to the hospital.

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On 2/3/2016, at 11:28 a.m. R95's smoking products, a 16 ounce bag of tobacco, cigarette rolling machine, and loose tobacco are observed on R95's over the bed table tray. Family member-(FM)-A stated, that smoking stuff was always out like that, and she was not even here. It always smells like tobacco in here.

On 2/3/2016, at 3:36 p.m. LPN-B stated, she was not sure what R85's care plan said about smoking or smoking products or where she was suppose to keep them. LPN-B verified R95's smoking products, tobacco, roller, cigarettes and loose tobacco were on a tray on the over the bed table in R95's room. LPN stated, she was not sure what was suppose to be done with them. The other resident who smokes on this wing locked them in his drawer. LPN-B verified there were residents who had confusion and wandered on the wing.

On 2/3/2016, at 3:40 p.m. RN-D stated, she did not know what R95's smoking plan was or how her smoking materials were supposed to be secured. RN-D stated she was aware when R95 was in the building, her smoking supplies were not secured. RN-D verified she had completed R95's Smoking Safety Assessment on 1/13/16.

On 2/3/2016, at 3:44 p.m. the DON stated she was unsure what R95's smoking plan was and would have to check the policy and find the information for R95's plan for smoking and storage. The DON verified R95 was readmitted to the hospital last night and was not in the facility. The DON stated she would go and put R95's smoking materials away right now.

On 2/3/2016, at 5:59 p.m. the DON verified

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F 323	Continued From page 87 R95's care plan did not reflect a smoking plan and her smoking products should have been secured, especially when a resident was not in the facility. On 2/3/2016, at 7:08 p.m. the DON stated, I want you to know we are taking this smoking issue very seriously, I do understand about wandering residents and the need to secure products. We are looking at all of the residents who smoke right now, I did not find R95's cigarette lighters. I took her jacket and smoking products to the social workers office. The DON verified the smoking policy was not followed, the tobacco products should have been secured and R95's care plan should have reflected her smoking plan including tobacco product storage. The facility, Resident Smoking Guidelines, updated 5/14/14 indicated All smoking materials must be kept secure for the safety of all residents.	F 323		
F 329 SS=E	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	F 329		3/21/16

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F 329	Continued From page 88 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 the appropriate justification for the use of an antidepressant and / or antipsychotic for 2 of 6 residents (R153, R139) who received a routine dose of Trazadone or Seroquel, failed to ensure target behaviors and non pharmalogical interventions were developed, implemented and / or monitored to ensure efficacy of psychotropic medications for 3 of 6 residents (R153, R139, R136) who received as needed (PRN) antipsychotic medication and / or PRN antianxiety medication without non-pharmocological interventions attempted prior to the administration of the medication. In addition, the facility failed to ensure a tapering dose reduction of an antidepressant was attempted or contraindications of the reduction documented for 1 of 6 residents (R75) who had received a daily antidepressant without a trial dose reduction attempted. Findings include:	F 329	Resident 153, 139,136 and 75 medications have been reviewed and Gradual Dose Reductions have been requested from the MD. Targeted behaviors and non-pharmacological interventions have been developed, implemented and monitored All resident receiving antipsychotic medications have the potential to be affected by this practice, but none show any negative outcome. Nursing staff have been re-educated on unnecessary drugs including targeted behaviors, non-pharmacological interventions, and gradual dose reductions. Psychotropic medication Audits will be completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and	

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F 329	Continued From page 89 R153 was routinely administered Trazadone (antidepressant) without appropriate diagnoses. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of the as needed (PRN) Seroquel (antipsychotic). R153's Physician Order sheet dated 2/4/16, indicated R153 had diagnoses which included Parkinson's disease, chronic obstructive pulmonary disease (a lung condition), and Lewy Body dementia (an aggressive dementia which can cause hallucinations, rigid muscles, slowed movement and tremors). R153's quarterly Minimum Data Set (MDS) dated 11/21/15, indicated R153 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of psychosis nor behavior towards self or others, and received a daily dose of an antipsychotic and antidepressant medication. R153's Behavioral Symptoms Care Area Assessment (CAA) dated 9/2/15, indicated R153 had no hallucinations, however, had shown signs of dementia and delirium. In addition, R153's Psychotropic Drug Use CAA dated 9/11/15, indicated R153 was taking an antipsychotic and an antidepressant medication. R153's physician orders dated 2/4/16, included the following: - Seroquel 50 mg (milligrams) twice a day which was started 5/22/15.	F 329	trends of audits to QAA committee. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 329	Continued From page 90 - Seroquel 100 mg at bedtime which was started 7/8/15. - Seroquel 50 mg PRN up to three times a day which was started 9/15/14. - Gabapentin (anticonvulsant medication) 100 mg three times a day which was started 10/14/14. - Trazodone (antidepressant) 75 mg daily started on 11/21/14. R153's care plan dated 11/25/15, identified a focus area for psychotropic drug use related to agitation with severe encephalopathy, severe Parkinsonism and Lewy body dementia which was initiated on 9/25/14. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, abnormal involuntary movement scale (AIMS) per facility policy and review for potential side effects. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN Seroquel. The care plan also identified a focus area for mood and behavior which indicated R153 displayed hitting and swearing with cares. The interventions included offer to walk the resident, leave the resident alone and return, try a different caregiver, try a different approach and offer apple juice. Fax Cover Letter to R153's physician dated 1/5/16, indicated R153 was currently taking four psychotropic medications: Med #1 - Seroquel Med #2 - Depakote sprinkles (medication to treat seizures or bipolar disease)	F 329		

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F 329	Continued From page 91 Med #3 - Trazodone Med #4 - Neurontin (anticonvulsant medication) R153's physician indicated the target behaviors for all of these listed medications was "anxiety." In addition, the physician indicated the diagnoses for justification for all these medications was "depression." R153's Target Behavior forms for 12/1/15 - 2/4/16, identified R153's target behavior as hitting and swearing at staff with cares. Approaches identified included secure others and resident safety and leave resident alone, wait ten minutes and return, try a different caregiver, speak calmly and slowly. R153's Medication Administration Record (MAR) for 12/1/15 - 2/4/16, was reviewed and indicated R153 had received Trazodone 75 mg daily. In addition, R153's MAR, nursing progress notes and behavior sheets were reviewed and revealed R153 received Seroquel 50 mg PRN 14 times from 12/1/15 - 2/4/16. The medical record lacked the following information related the use of the PRN Seroquel: -Documentation of target behaviors (hitting and swearing at staff with cares) six out of the 14 times 12/10/15, and 12/14/15 (R153 was given 3 doses on this day), 12/17/15, 12/20/15, 1/14/16) all lacked target behaviors resulting in the administration of the PRN medication. -Documentation of non-pharmacological interventions trialed prior to the administration of the PRN Seroquel eight out of 14 times on	F 329		

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F 329	Continued From page 92 12/7/15, 12/10/15, 12/14/15 (given three doses only documentation for one dose), 12/17/15, 12/19/15, 12/20/15, and 1/14/16. On 2/3/16, at 8:13 a.m. nursing assistant (NA)-J was observed to utilize a sit to stand lift and assisted R153 into the bathroom. R153 took direction well and was not resistive to cares. On 2/4/16, at 2:43 p.m. R153 was observed seated in his tilt back wheelchair stationed on the outskirts of the nursing station. R153 was alert, calm and watched as other staff and residents passed by. On 2/5/16, at 1:16 p.m. licensed practical nurse (LPN)-D verified R153 had PRN Seroquel ordered. LPN-D stated R153 usually received the PRN Seroquel four to five times a month when R153 exhibited behaviors such as hitting or punching staff. When asked about non-pharmacological interventions, LPN-D stated they could offer R153 apple juice or give him a ride in his wheelchair. LPN-D stated overall, the staff could do a better job of documenting the target behaviors exhibited and non-pharmacological interventions attempted. On 2/5/16, at 1:41 p.m. registered nurse (RN)-B confirmed the expectation was for staff to document the specific behavior exhibited by R153 and the non-pharmacological interventions trialed prior to the administration of the PRN Seroquel. In addition, target behaviors and non-pharmacological interventions should	F 329		

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specifically be identified on the care plan. RN-B confirmed R153's care plan lacked these specifics.

On 2/5/16, at 2:02 p.m. consulting pharmacist (CP)-A confirmed the depression diagnosis listed on the fax cover letter dated 1/5/16, for Seroquel, Depakote and Neurontin were not acceptable indications for use. In addition, anxiety listed as a target behavior was not specific. CP-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R153's PRN Seroquel.

R139 was routinely administered Seroquel without an appropriate diagnosis for it's use. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of PRN lorazepam (Ativan) (antianxiety).

R139's Physician Order sheet dated 1/12/16, indicated R139 had diagnoses which included acute confusional state and dementia. R139's Integrated Problem List/Diagnostic Records, undated, indicated R139 was diagnosed with dementia with agitation.

R139's's quarterly MDS dated 1/19/16, indicated R139 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R139's Behavioral

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F 329	Continued From page 94 Symptoms CAA dated 8/3/15, indicated R139 had shown signs of dementia and delirium. In addition, R139's Psychotropic Drug Use CAA dated 8/14/15, indicated R139 had dementia with agitation and was taking an antipsychotic medication. R139's physician orders dated 1/12/16, included the following: -Quetiapine (Seroquel) 25 mg twice a day which was started 2/5/15. -Lorazepam 0.5 mg 1/2 tablet twice daily PRN which was started 11/30/15. R139's care plan dated 1/28/16, identified a focus area for psychotropic drug use due to Alzheimer's dementia. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, observe for lethargy and need for med reduction and complete the abnormal involuntary movement scale (AIMS) per facility policy. The care plan indicated R139 was noncompliant with care plan due to dementia and was at risk for effects related to refusal of medication, treatments and cares and directed staff to notify R139's physician, offer alternative to enhance compliance such as leave resident safe and reapproach, have another staff member approach, notify team lead as needed and to document refusals. The care plan also identified a focus area for mood and behavior which indicated R139 spent a great deal of time sitting in own room quietly. R139 experienced confusion with new things, wandered daily and had difficulty finding own room, and became agitated/frustrated	F 329		

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F 329	Continued From page 95	F 329		

when staff completed verbal assessments with her. The interventions included encourage to participate in planned activities, redirect as needed, conversation to calm and take to a quiet area. In addition, the care plan indicated R139 wandered aimlessly, was at risk for exit seeking and had impaired safety awareness and directed staff to assess for fall risk, code alert to ankle, monitor for fatigue and weight loss and provide structured activities. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN lorazepam.

The Fax Cover Letter to R139's physician dated 6/10/14, indicated last month a request for a diagnosis for Seroquel was sent with a reply of dementia with agitation to-control agitation. According to CMS (Centers for Medicare & Medicaid Services) guidelines, that is not an appropriate diagnosis. Please provide a different diagnosis for Seroquel and why. Response: This is off label-use of Seroquel for dementia with agitation.

The Fax Cover Letter dated 2/3/16, which indicated R139's physician declined a dose reduction of the Seroquel due to a history of failed reduction with increased aggressive behaviors, wandering and resisted cares.

R139's MAR indicated R139 utilized lorazepam 0.5 mg 1/2 tablet BID on 12/8/15, for restlessness/agitation, on 12/18/15, for anxiety/restless/wandering, on 1/1/16, for anxiety,

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F 329	Continued From page 96 1/4/16, for anxiety, 1/9/16, was anxious,1/13/16, for refused PRN med prior to catheter use for a urine sample, 1/21/16, for anxiety and 1/30/16, due to wandering and refusing blood pressure assessment. R139's pharmacy reviews indicated no new recommendations during the 1/27/16, 12/15/15, and 11/5/15, pharmacy review. R139's medical record lacked Target Behavior Forms. On 2/3/16, at 8:15 a.m. RN-E stated R139 had not utilized the PRN Ativan in February to date, but did use it in January. RN-E stated R139 was administered the PRN medication if she had increased anxiety. RN-E stated the use would be documented on the MAR and identified it was used for anxiety. RN-E stated she did not know what target behaviors or non-pharmacological interventions were to be attempted prior to administering the medication, therefore, had not documented such. RN-E stated R139's target behaviors nor interventions were not identified on the MAR. On 2/3/16, at 1:50 p.m. RN-D stated the diagnosis for the Seroquel use was dementia with agitation - to control agitation. RN-D provided and reviewed the 6/10/14, fax cover sheet and verified it had been submitted to R139's physician requesting an appropriate diagnosis for Seroquel. RN-D stated the physician did not change the diagnosis and stated she should not have to put	F 329		

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F 329	Continued From page 97 her nursing license on the line to make sure a doctor did their job and she should not have to keep addressing the need for the diagnosis. RN-D stated she did not know what R139's target behaviors were or what non-pharmacological interventions were to be attempted. RN-D verified there was no information related to target behaviors or non-pharmacological interventions to be attempted prior to the Adminstation of the PRN Lorazepam identified on R139's MAR or care plan. On 2/3/16, at 2:03 p.m. the licensed social worker (LSW) stated target behaviors and non-pharmacological interventions should have been listed on R139's MAR right below lorazepam PRN was indicated. LSW stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the resident's target behaviors which should be identified on their individual MAR in order to monitor and implement interventions prior to the medication use. The LSW verified R139's medical record, care plan and MAR lacked target behaviors and non-pharmacological interventions to be attempted and stated they should be there, "I do not know why they are not." On 2/3/16, at 2:33 p.m. the DON verified target behaviors and non-pharmacological interventions should have been identified, monitored and attempted prior to administering R139's PRN lorazepam. In addition, the DON stated R139's care plan should have reflected the information as well. The DON stated it was her expectation staff would have identified target behaviors and attempted non-pharmacological interventions	F 329		

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F 329	Continued From page 98 before administering the medication. On 2/5/16, at 2:12 p.m. CP-A confirmed the dementia diagnosis listed on the fax cover letter dated 6/10/14, for Seroquel, was not an acceptable indication for use. CP-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R139's PRN Lorazepam. R136 was prescribed risperidone (Risperdal) (antipsychotic) PRN and target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of the as needed (PRN) risperidone medication. R136's Integrated Problem List/Diagnostic Records sheet undated, indicated R136 had diagnoses which included dementia with paranoid thoughts, diabetes mellitus, and hyperlipidemia. R136's quarterly MDS dated 1/6/16, indicated R136 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R136's Psychotropic Drug Use CAA dated 8/3/15, indicated R136 was taking an antipsychotic medication. R136's physician orders dated 1/31/16 and	F 329		

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F 329	Continued From page 99 12/3/15, included the following: -Risperidone 0.25 mg twice a day which was started 8/7/14. -Risperidone 0.5 mg 1/2 tablet twice daily PRN started 1/9/15. R136's care plan dated, identified a focus area for psychotropic drug use. The interventions included medication as ordered, observe for medication effectiveness, abnormal involuntary movement scale (AIMS) per facility policy. However, the care plan lacked identification of target behaviors and nonpharmacological interventions to be attempted prior to the administration of the PRN risperidone. The care plan also identified a focus area for mood and behavior which indicated R136 displayed wandering and became paranoid and believes others have stolen her belongings. R136 was easily redirected and directed staff to listen to concerns, redirect, encourage activities and to check for thirst, toileting pain and hunger. R136's MAR indicated R136 utilized Risperidone 0.5 mg 1/2 tablet on 1/5/16, and 1/8/16, for increased agitation and 1/9/16, for anxiety. No use in December 2015, and no use in February to date. R136's pharmacy reviews revealed the following: - 1/26/16, recommendations for reduction of omeprazole 20 mg to 10 mg (gastric medication) - 12/18/15, no recommendations - 11/8/15, no recommendations.	F 329		

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F 329	Continued From page 100 On 2/3/16, at 11:15 a.m. R136 was observed in the dining room at an activity event. No behaviors observed. On 2/3/16, at 2:03 p.m. LSW-A stated target behaviors and non-pharmacological interventions should have been listed on R136's MAR right below the medication. LSW-A stated there are no behavior monitoring sheets for R136. LSW-A stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which were then identified on the MAR for monitoring and implementation of interventions prior to PRN medication use. On 2/3/16, at 2:33 p.m. the DON verified target behaviors/nonpharmacological interventions should have been attempted prior to the administration of the medication and monitored. The DON stated R136's care plan should have also reflected that same information. The DON stated it was her expectation that staff would be attempting nonpharmacological interventions before administering the medication as well as target behaviors identified. On 2/4/16, at 10:56 a.m. RN-C stated R136 had not target behaviors or non-pharmacological interventions listed for the use of Risperidone. RN-C stated she had seen documentation on other resident MARs but not on R136's. RN-C stated she could list the interventions that worked for R136 and that they just were not written down, "I don't know why." RN-C stated she did not think	F 329		

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F 329	Continued From page 101 R126 needed the PRN medication because she was easily redirected. On 2/4/16, at 1:59 p.m. RN-B stated target behaviors and non-pharmacological interventions should have been identified for R136. RN-B stated she would expect staff to attempt non-pharmacological's prior to administering PRN medication and document such. RN-B verified there were no target behaviors or non-pharmacological interventions found in R136's medical record or on the care plan. On 2/4/16, at 2:30 p.m. R136 was observed sitting in her wheelchair visiting with her son. No behaviors observed. On 2/5/16, at 2:12 p.m. CP-A confirmed target behaviors and nonpharmacological interventions should have been identified, implemented and monitored for R136's PRN Risperidone use. R75 received an antidepressant medication (fluoxetine) and a tapering dose reduction was not attempted or contraindications for tapering documented, as required. R75's quarterly MDS dated 12/23/15, indicated R75 was cognitively intact and had diagnoses which included stroke, anxiety disorder and dementia. The MDS also identified mood symptoms which included feeling down, depressed, or hopeless one day, feeling tired or having little energy nearly everyday and feeling	F 329		

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F 329	Continued From page 102 bad about herself several days during the assessment period. The MDS further indicated R75 did not have hallucinations, delusions or any behavioral symptoms and exhibited no rejection of care of wandering and received antidepressant medication daily. R75's Psychotropic Drug Use Care Area Assessment (CAA) dated 9/25/15, indicated with the use of an antidepressant medication, R75 was at risk for undesirable side effects or aggravating signs and symptoms of existing conditions. R75's Activities of Daily Living Functional/Rehabilitation CAA dated 9/25/15, indicated R75 had minimal symptoms of depression, felt down and bad about her situation, had poor sleep and a poor appetite. The CAA also indicated R75 was at risk for invalidism, diminished self worth, and a feeling of loss of control over one's own destiny. During interview on 02/2/16, at 11:14 a.m. R75 spent most of the time speaking with her eyes closed. R75's voice was tearful and her face was strained as she expressed concerns regarding her finances and paperwork, as well as concerns regarding her son and trusting the facility social workers regarding her bills. On 02/05/2016, at 9:39 a.m. R75 was observed seated at the edge of her bed dressed in a hospital style gown. No behaviors were observed.	F 329		

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F 329	Continued From page 103 On 02/09/2016, at 8:36 a.m. R75 was seated at chair in Elm dining room at breakfast. RN-I attempted to give R75 her medication. R75 questioned what the pills were and refused to take them. On 02/09/2016, at 9:30 a.m. R75 remained seated at the table in the dining room, resting with here eyes closed. No behaviors observed. R75's Physician Orders dated 1/13/16, indicated R75 was prescribed fluoxetine 40 mg daily. The orders indicate R75 was started on the medication 9/9/15 R75's Care Plan dated 12/23/15, identified a focus of psychotropic drug use and directed staff to administer medications as ordered, observe for medication effectiveness, symptoms of mood/behavior improvement or decline, observe for lethargy, need for medication reduction and to review observations with the physician. The Care Plan also directed staff to review medication potential side effects with the resident and/or person in charge of health care decisions for informed consents and review for possible medication reductions. Review of the Consultant Pharmacist's Medication Regimen Reviews identified the pharmacist reviewed R75's medicaiton regimen on the following dates: 1/14/15, 2/26/15, 3/11/15, 4/15/15, 5/15/15,	F 329		

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6/12/15, 7/7/15, 8/10/15, 9/11/15, 10/7/15, 11/4/15, 12/16/15, and 1/22/16. On 6/12/15, the pharmacist indicated R75 currently used fluoxetine 20 mg daily and recommended a dose reduction to 10 mg per day be considered to ensure the lowest effective dose was being used or if a reduction was not appropriate recommended documentation of the contraindication.

R75's Physician Orders hand written order dated 9/9/15, indicated to increase fluoxetine to 40 mg daily.

Review of R75's Physician Nursing Home Reports revealed the following:
-7/8/15: She continues to be anxious, weepy. She is not really happy with her situation. The physician did not address the pharmacist recommendation to taper the dose of fluoxetine
-9/9/15: She is alert, again weepy, anxious, agitated. Impression: progressive age-related and also vascular dementia, I think now with some confusion, some paranoid thought, some emotional lability. The physician did not provide a rationale for increasing fluoxetine from 20 mg to 40 mg daily.
-11/11/15: She continues to be somewhat agitated. Medications are reviewed. She has been on fluoxetine 40 mg after her stroke. No further documentation regarding use of fluoxetine 40 mg daily.
-1/13/16: voiced some increased anxiety. I think she would probably do better if we could find some task or duty that she could do, give her some value and in summary positive reinforcement. I encouraged staff to get her involved in activities. No further documentation

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F 329	Continued From page 105 regarding use of fluoxetine 40 mg daily. On 02/09/2016, at 10:54 a.m. RN-I confirmed R75 refused her fluoxetine and stated R75 had refused her fluoxetine the past 5 days. RN-F stated she had contacted the physician regarding the medication refusal. RN-F also stated R75's mood had been stable and she had been out of her room more since refusing the medication. However, she had been somewhat more suspicious of staff. On 02/09/2016, at 2:05 p.m. R75 stated she was feeling much better. R75 stated her prescription for depression had been increased awhile ago but she didn't like how it made her feel. R75 stated she stopped taking it a few days ago and has felt better since then. R75's affect was bright and smiling. R75 stated she felt like a new person. On 02/09/2016, at 2:38 p.m. RN-F confirmed R75 was on fluoxetine when she was admitted to the facility over a year ago and a tapering of the medication had not been attempted. RN-F stated R75 had actually had an increase in the dosage of medication and verified there had not been a documentation of the rationale for the increase nor documentation of a contraindication for an attempted decrease of the medication. RN-F stated R75's mood had been more stable since refusing the medication. Medication Administration Record policy dated 3/1/14, indicated all medications would have a	F 329		

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F 329	Continued From page 106 specific reason for use. Unnecessary Drugs-Antipsychotic Drugs policy dated 4/2009, indicated psychotropic drug therapy should only be used when necessary to treat a specific condition as diagnosed and documented in the clinical record. In addition, prior to the administration of a PRN antipsychotic, justification of use must be documented in the medical record which included reasons why the medication was given and what nonpharmacological interventions were tried prior to administration.	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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the kitchen food storage, preparation and service areas in a clean and sanitary manner. This has the potential to affect all 139 residents who received meals prepared in the kitchen.	F 371	The facility has made the repairs in the kitchen food storage area, preparation and service areas to assure it is in clean and sanitary condition. All residents that have food prepared in this facility have the potential to be affected by this practice, but none show any negative outcome.	3/21/16

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F 371	Continued From page 107 Findings include: On 2/1/16, at 4:02 p.m. an initial tour of the kitchen was done with the dietary director (DD). On 2/3/16, at 1:27 p.m. a revisit tour was also conducted with the DD and the corporate consultant (CC)-B and the following concerns were observed: -The ceiling tiles had approximately 1 x 3 inch peeling paper strips hanging from the tiles above the large floor mixer. The DD stated the ceiling would be taken care of right away. -The ceiling tiles above the large coffee makers had peeling paper areas which ranged from approximately two to six inches in length. The metal support strips holding the tiles in place were rusted and paint was peeling. The ceiling tiles above the four-three shelf carts which the uncovered and open carafes were kept, had peeling ceiling tiles with two to six inch paper pieces hanging. The DD verified there was a potential for dust and debris to fall from the peeling paper into carafes and coffee service pots. -There were six loaves of bread observed on the counter. The DD verified toast and sandwiches were prepped on the counter. The ceiling tiles above the counter had numerous peeling paper pieces ranging from 1/5 inches -2/3 inches hanging down from the ceiling over the counter. The DD stated she would get those removed immediately. The DD further stated, the hanging	F 371	A cleaning schedule has been developed and adopted into practice. A new policy and procedure has been developed and adopted into practice. Dietary staff have been re-educated on proper techniques of a clean and sanitary kitchen that includes food and storage, and preparation and service areas. Clean and sanitary kitchen audits will be conducted weekly x 3 months and then reevaluated by QAA. The Dietary manager or designee will report results and trends of audits to the QAA and follow up as needed. It is the responsibility of the Dietary Manager or designee to ensure compliance.	

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F 371	Continued From page 108 pieces could have dust and debris which could fall on to the counter, bread and toaster which caused a risk of food contamination. -The range hood above the cook stove has three panels which had dust and debris build up. The DD stated this was scheduled to be cleaned shortly as it was usually done every two weeks. On 02/03/2016, at 10:59 a.m. CC-B stated the kitchen was on the facility's remodel list to be completed after the remodeling of resident rooms was completed. The CC-B agreed the kitchen needed to be cleaned and stated staff would be getting the aforementioned areas cleaned up right away. CC-B added, just because the kitchen was old, it did not have to be dirty. On 02/03/2016, at 1:35 p.m.. the DD verified all of the aforementioned areas were not clean and sanitary which could have potentially caused a food born illness concern. The DD stated they had cleaning schedules and assignments set up and staff coming in tonight to clean. The DD further stated she would get the peeling paper removed from the ceiling tiles, the food prep and other areas cleaned up right away. The DD stated the kitchen did not have anyone specific to do deep cleaning rather it was completed daily, after us. The DD stated maintenance and housekeeping were involved with night cleaning. The DD stated staff needed to do a better job of cleaning. The Department of Dietary - Department	F 371		

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F 371	Continued From page 109 Cleaning Policy, updated 3/25/14, indicated the equipment, storage and work areas in the dietary department would be kept clean and safe for food handling, preparation and service.	F 371		
F 428 SS=E	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 observation, interview and document review the facility failed to ensure the consulting pharmacist identified the lack of the appropriate justification for the use of an antidepressant and / or an antipsychotic medication for 2 of 6 residents (R153, R139) who received a routine dose of trazadone or Seroquel, failed to ensure target behaviors and non pharmalogical interventions were developed, implemented and / or monitored to ensure efficacy of psychotropic medications for 3 of 6 residents (R153, R139, R136) who received as needed (PRN) antipsychotic medication and / or PRN antianxiety medication. In addition, the consulting pharmacist failed to identify the lack of a tapering dose reduction of an antidepressant use had been attempted or contraindications of the reduction documented for	F 428	Resident 153, 139,136 medical records have been reviewed and target behaviors, non-pharmacological interventions and gradual dose reduction have been developed. Resident 75 medications have been reviewed and Gradual Dose Reductions have been requested from the MD. The consulting R.Ph has been educated on her role to review medications and identify improper diagnosis: target behaviors; non-pharmacological interventions; and gradual dose reduction. All resident receiving antipsychotic medications have the potential to be affected by this practice, but none show any negative outcome.	3/21/16

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F 428	Continued From page 110 1 of 6 residents (R75) who had received a daily antidepressant without a trial dose reduction attempted. Findings include: R153 received a daily dose of trazadone without an appropriate justification for use identified. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of the PRN Seroquel (antipsychotic). R153's Physician Order sheet dated 2/4/16, indicated R153 had diagnoses which included Parkinson's disease, chronic obstructive pulmonary disease (a lung condition), and Lewy Body dementia (an aggressive dementia which can cause hallucinations, rigid muscles, slowed movement and tremors). R153's quarterly Minimum Data Set (MDS) dated 11/21/15, indicated R153 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of psychosis nor behavior towards self or others, and received a daily dose of an antipsychotic and antidepressant medication. R153's Behavioral Symptoms Care Area Assessment (CAA) dated 9/2/15, indicated R153 had no hallucinations, however, had shown signs of dementia and delirium. In addition, R153's Psychotropic Drug Use CAA dated 9/11/15, indicated R153 was taking an antipsychotic and an antidepressant	F 428	Pharmacy consult audits will be completed monthly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 428	Continued From page 111 medication. R153's care plan dated 11/25/15, identified a focus area for psychotropic drug use related to agitation with severe encephalopathy, severe Parkinsonism and Lewy body dementia which was initiated on 9/25/14. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, abnormal involuntary movement scale (AIMS) per facility policy and review for potential side effects. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN Seroquel. The care plan also identified a focus area for mood and behavior which indicated R153 displayed hitting and swearing with cares. The interventions included offer to walk the resident, leave the resident alone and return, try a different caregiver, try a different approach and offer apple juice. Fax Cover Letter to R153's physician dated 1/5/16, indicated R153 was currently taking four psychotropic medications: Med #1 - Seroquel Med #2 - Depakote sprinkles (medication to treat seizures or bipolar disease) Med #3 - Trazodone Med #4 - Neurontin (anticonvulsant medication) R153's physician indicated the target behaviors for all of these listed medications was "anxiety." In addition, the physician indicated the diagnoses for justification for all these medications was "depression."	F 428		

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F 428	Continued From page 112	F 428		

R153's Target Behavior forms for 12/1/15 - 2/4/16, identified R153's target behavior as hitting and swearing at staff with cares. Approaches identified included secure others and resident safety and leave resident alone, wait ten minutes and return, try a different caregiver, speak calmly and slowly.

R153's Medication Administration Record (MAR) for 12/1/15 - 2/4/16, was reviewed and indicated R153 had received Trazodone 75 mg daily. In addition, R153's MAR, nursing progress notes and behavior sheets were reviewed and revealed R153 received Seroquel 50 mg PRN 14 times from 12/1/15 - 2/4/16. The medical record lacked the following information related the use of the PRN Seroquel:

-Documentation of target behaviors (hitting and swearing at staff with cares) six out of the 14 times 12/10/15, and 12/14/15 (R153 was given 3 doses on this day), 12/17/15, 12/20/15, 1/14/16) all lacked target behaviors resulting in the administration of the PRN medication.
-Documentation of non-pharmacological interventions trialed prior to the administration of the PRN Seroquel eight out of 14 times on 12/7/15, 12/10/15, 12/14/15 (given three doses only documentation for one dose), 12/17/15, 12/19/15, 12/20/15, and 1/14/16.

The consulting pharmacist's monthly medication regimen review for R153, from 7/7/15 - 1/26/16, lacked mention of the need for an appropriate diagnosis for the use of trazodone and the identification and implementation of target behaviors and nonpharmacological interventions

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F 428	Continued From page 113 for the utilization of R153's PRN Seroquel. On 2/5/16, at 1:16 p.m. licensed practical nurse (LPN)-D verified R153 had PRN Seroquel ordered. LPN-D stated R153 usually received the PRN Seroquel four to five times a month when R153 exhibited behaviors such as hitting or punching staff. When asked about nonpharmacological interventions, LPN-D stated they could offer R153 apple juice, give him a ride in his wheelchair, however, LPN-D stated overall the staff could do a better job of documenting the target behaviors and nonpharmacological interventions. On 2/5/16, at 1:41 p.m. registered nurse (RN)-B confirmed the expectation was for staff to document the specific behavior exhibited by R153 and the nonpharmacological interventions trialed prior to the administration of the PRN Seroquel. In addition, target behaviors and nonpharmacological interventions should specifically be identified on the care plan. RN-B confirmed R153's care plan lacked these specifics. On 2/5/16, at 2:02 p.m. consulting pharmacist (CP)-A confirmed the depression diagnosis listed on the fax cover letter dated 1/5/16, for Seroquel, Depakote and Neurontin were not acceptable indications for use and anxiety listed as a target behavior was not specific. CP-A confirmed target behaviors and nonpharmacological interventions should be identified and implemented for R153's PRN Seroquel. CP-A confirmed the consultant pharmacist's monthly medication regimen reviews	F 428		

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F 428	Continued From page 114 included assuring appropriate diagnoses where identified for medication and that target behaviors and nonpharmacological interventions were identified and implemented for a PRN antipsychotic. R139 was routinely administered Seroquel without an appropriate diagnosis for it's use. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of PRN lorazepam (Ativan) (antianxiety). R139's Physician Order sheet dated 1/12/16, indicated R139 had diagnoses which included acute confusional state and dementia. R139's Integrated Problem List/Diagnostic Records, undated, indicated R139 was diagnosed with dementia with agitation. R139's's quarterly MDS dated 1/19/16, indicated R139 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R139's Behavioral Symptoms CAA dated 8/3/15, indicated R139 had shown signs of dementia and delirium. In addition, R139's Psychotropic Drug Use CAA dated 8/14/15, indicated R139 had dementia with agitation and was taking an antipsychotic medication. R139's physician orders dated 1/12/16, included	F 428		

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F 428	Continued From page 115 the following: -Quetiapine (Seroquel) 25 mg twice a day which was started 2/5/15. -Lorazepam 0.5 mg 1/2 tablet twice daily PRN which was started 11/30/15. R139's care plan dated 1/28/16, identified a focus area for psychotropic drug use due to Alzheimer's dementia. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, observe for lethargy and need for med reduction and complete the abnormal involuntary movement scale (AIMS) per facility policy. The care plan indicated R139 was noncompliant with care plan due to dementia and was at risk for effects related to refusal of medication, treatments and cares and directed staff to notify R139's physician, offer alternative to enhance compliance such as leave resident safe and reapproach, have another staff member approach, notify team lead as needed and to document refusals. The care plan also identified a focus area for mood and behavior which indicated R139 spent a great deal of time sitting in own room quietly. R139 experienced confusion with new things, wandered daily and had difficulty finding own room, and became agitated/frustrated when staff completed verbal assessments with her. The interventions included encourage to participate in planned activities, redirect as needed, conversation to calm and take to a quiet area. In addition, the care plan indicated R139 wandered aimlessly, was at risk for exit seeking and had impaired safety awareness and directed staff to assess for fall risk, code alert to ankle, monitor for fatigue and weight loss and provide	F 428		

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F 428	Continued From page 116 structured activities. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN lorazepam. The Fax Cover Letter to R139's physician dated 6/10/14, indicated last month a request for a diagnosis for Seroquel was sent with a reply of dementia with agitation to-control agitation. According to CMS (Centers for Medicare & Medicaid Services) guidelines, that is not an appropriate diagnosis. Please provide a different diagnosis for Seroquel and why. Response: This is off label-use of Seroquel for dementia with agitation. The Fax Cover Letter dated 2/3/16, which indicated R139's physician declined a dose reduction of the Seroquel due to a history of failed reduction with increased aggressive behaviors, wandering and resisted cares. R139's MAR indicated R139 utilized lorazepam 0.5 mg 1/2 tablet BID on 12/8/15, for restlessness/agitation, on 12/18/15, for anxiety/restless/wandering, on 1/1/16, for anxiety, 1/4/16, for anxiety, 1/9/16, was anxious,1/13/16, for refused PRN med prior to catheter use for a urine sample, 1/21/16, for anxiety and 1/30/16, due to wandering and refusing blood pressure assessment. R139's pharmacy reviews indicated no new recommendations during the 1/27/16, 12/15/15,	F 428		

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F 428	Continued From page 117 and 11/5/15, pharmacy review. R139's medical record lacked Target Behavior Forms. On 2/3/16, at 8:15 a.m. RN-E stated R139 had not utilized the PRN Ativan in February to date, but did use it in January. RN-E stated R139 was administered the PRN medication if she had increased anxiety. RN-E stated the use would be documented on the MAR and identified it was used for anxiety. RN-E stated she did not know what target behaviors or non-pharmacological interventions were to be attempted prior to administering the medication, therefore, had not documented such. RN-E stated R139's target behaviors nor interventions were not identified on the MAR. On 2/3/16, at 1:50 p.m. RN-D stated the diagnosis for the Seroquel use was dementia with agitation - to control agitation. RN-D provided and reviewed the 6/10/14, fax cover sheet and verified it had been submitted to R139's physician requesting an appropriate diagnosis for Seroquel. RN-D stated the physician did not change the diagnosis and stated she should not have to put her nursing license on the line to make sure a doctor did their job and she should not have to keep addressing the need for the diagnosis. RN-D stated she did not know what R139's target behaviors were or what non-pharmacological interventions were to be attempted. RN-D verified there was no information related to target behaviors or non-pharmacological interventions to be attempted prior to the administration of the	F 428		

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F 428	Continued From page 118 PRN Lorazepam identified on R139's MAR or care plan. On 2/3/16, at 2:03 p.m. the licensed social worker (LSW) stated target behaviors and non-pharmacological interventions should have been listed on R139's MAR right below lorazepam PRN was indicated. LSW stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the resident's target behaviors which should be identified on their individual MAR in order to monitor and implement interventions prior to the medication use. The LSW verified R139's medical record, care plan and MAR lacked target behaviors and non-pharmacological interventions to be attempted and stated they should be there, "I do not know why they are not." On 2/3/16, at 2:33 p.m. the DON verified target behaviors and non-pharmacological interventions should have been identified, monitored and attempted prior to administering R139's PRN lorazepam. In addition, the DON stated R139's care plan should have reflected the information as well. The DON stated it was her expectation staff would have identified target behaviors and attempted non-pharmacological interventions before administering the medication. On 2/5/16, at 2:12 p.m. CP-A confirmed the dementia diagnosis listed on the fax cover letter dated 6/10/14, for Seroquel, was not an acceptable indication for use. CP-A confirmed target behaviors and non-pharmacological interventions should have been identified and	F 428		

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F 428	Continued From page 119 implemented for R139's PRN Lorazepam. R136 was prescribed risperidone (Risperdal) (antipsychotic) PRN and target behaviors and non-pharmacological interventions were not consistently identified, trialed and monitored prior to the administration of the as needed (PRN) risperidone medication. R136's Integrated Problem List/Diagnostic Records sheet undated, indicated R136 had diagnoses which included dementia with paranoid thoughts, diabetes mellitus, and hyperlipidemia. R136's quarterly MDS dated 1/6/16, indicated R136 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R136's Psychotropic Drug Use CAA dated 8/3/15, indicated R136 was taking an antipsychotic medication. R136's physician orders dated 1/31/16 and 12/3/15, included the following: -Risperidone 0.25 mg twice a day which was started 8/7/14. -Risperidone 0.5 mg 1/2 tablet twice daily PRN started 1/9/15.	F 428		

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F 428	Continued From page 120 R136's care plan dated, identified a focus area for psychotropic drug use. The interventions included medication as ordered, observe for medication effectiveness, abnormal involuntary movement scale (AIMS) per facility policy. However, the care plan lacked identification of target behaviors and nonpharmacological interventions to be attempted prior to the administration of the PRN risperidone. The care plan also identified a focus area for mood and behavior which indicated R136 displayed wandering and became paranoid and believes others have stolen her belongings. R136 was easily redirected and directed staff to listen to concerns, redirect, encourage activities and to check for thirst, toileting pain and hunger. R136's MAR indicated R136 utilized Risperidone 0.5 mg 1/2 tablet on 1/5/16, and 1/8/16, for increased agitation and 1/9/16, for anxiety. No use in December 2015, and no use in February to date. R136's pharmacy reviews revealed the following: - 1/26/16, recommendations for reduction of omeprazole 20mg to 10mg (gastric medication) - 12/18/15, no recommendations - 11/8/15, no recommendations. On 2/3/16, at 11:15 a.m. R136 was observed in the dining room at an activity event. No behaviors observed. On 2/3/16, at 2:03 p.m. LSW-A stated target behaviors and non-pharmacological interventions	F 428		

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F 428	Continued From page 121 should have been listed on R136's MAR right below the medication. LSW-A stated there are no behavior monitoring sheets for R136. LSW-A stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which were then identified on the MAR for monitoring and implementation of interventions prior to PRN medication use. On 2/3/16, at 2:33 p.m. the DON verified target behaviors/nonpharmacological interventions should have been attempted prior to the administration of the medication and monitored. The DON stated R136's care plan should have also reflected that same information. The DON stated it was her expectation that staff would be attempting nonpharmacological interventions before administering the medication as well as target behaviors identified. On 2/4/16, at 10:56 a.m. RN-C stated R136 had not target behaviors or non-pharmacological interventions listed for the use of Risperidone. RN-C stated she had seen documentation on other resident MARs but not on R136's. RN-C stated she could list the interventions that worked for R136 and that they just were not written down, "I don't know why." RN-C stated she did not think R126 needed the PRN medication because she was easily redirected. On 2/4/16, at 1:59 p.m. RN-B stated target behaviors and non-pharmacological interventions should have been identified for R136. RN-B stated she would expect staff to attempt	F 428		

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F 428	Continued From page 122	F 428		

non-pharmacological's prior to administering PRN medication and document such. RN-B verified there were no target behaviors or non-pharmacological interventions found in R136's medical record or on the care plan.

On 2/4/16, at 2:30 p.m. R136 was observed sitting in her wheelchair visiting with her son. No behaviors observed.

On 2/5/16, at 2:12 p.m. CP-A confirmed target behaviors and nonpharmacological interventions should have been identified, implemented and monitored for R136's PRN Risperidone use.
R75 received a routine dose of an antidepressant medication (fluoxetine) without a tapering trial dose reduction attempted or contraindications for tapering documented.

R75's quarterly MDS dated 12/23/15, indicated R75 was cognitively intact and had diagnoses which included stroke, anxiety disorder and dementia. The MDS also identified mood symptoms which included feeling down, depressed, or hopeless one day, feeling tired or having little energy nearly everyday and feeling bad about herself several days during the assessment period. The MDS further indicated R75 did not have hallucinations, delusions or any behavioral symptoms and exhibited no rejection of care of wandering and received antidepressant medication daily.

R75's Psychotropic Drug Use CAA dated 9/25/15, indicated with the use of an antidepressant

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F 428	Continued From page 123 medication, R75 was at risk for undesirable side effects or aggravating signs and symptoms of existing conditions. R75's Activities of Daily Living Functional/Rehabilitation CAA dated 9/25/15, indicated R75 had minimal symptoms of depression, felt down and bad about her situation, had poor sleep and a poor appetite. The CAA also indicated R75 was at risk for invalidism, diminished self worth, and a feeling of loss of control over one's own destiny. During interview on 2/2/16, at 11:14 a.m. R75 spent most of the time speaking with her eyes closed. R75's voice was tearful and her face was strained as she expressed concerns regarding her finances and paperwork, as well as concerns regarding her son and trusting the facility social workers regarding her bills. On 02/05/2016, at 9:39 a.m. R75 was observed seated at the edge of her bed dressed in a hospital style gown. No behaviors were observed. On 02/09/2016, at 8:36 a.m. R75 was seated at chair in Elm dining room at breakfast. RN-I attempted to give R75 her medication. R75 questioned what the pills were and refused to take them. On 02/09/2016, at 9:30 a.m. R75 remained seated at the table in the dining room, resting	F 428		

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F 428	Continued From page 124 with here eyes closed. No behaviors observed. R75's Physician Orders dated 1/13/16, indicated R75 was prescribed fluoxetine 40 mg daily. The orders indicate R75 was started on the medication 9/9/15 R75's Care Plan dated 12/23/15, identified a focus of psychotropic drug use and directed staff to administer medications as ordered, observe for medication effectiveness, symptoms of mood/behavior improvement or decline, observe for lethargy, need for medication reduction and to review observations with the physician. The Care Plan also directed staff to review medication potential side effects with the resident and/or person in charge of health care decisions for informed consents and review for possible medication reductions. Review of the Consultant Pharmacist's Medication Regimen Reviews identified the pharmacist reviewed R75's medication regimen on the following dates: 1/14/15, 2/26/15, 3/11/15, 4/15/15, 5/15/15, 6/12/15, 7/7/15, 8/10/15, 9/11/15, 10/7/15, 11/4/15, 12/16/15, and 1/22/16. -On 6/12/15, the pharmacist indicated R75 currently used fluoxetine 20 mg daily and recommended a dose reduction to 10 mg per day be considered to ensure the lowest effective dose was being used or if a reduction was not appropriate recommended documentation of the contraindication.	F 428		

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F 428	Continued From page 125 R75's Physician Orders hand written order dated 9/9/15, indicated to increase fluoxetine to 40mg daily. Review of R75's Physician Nursing Home Reports revealed the following: -7/8/15: She continues to be anxious, weepy. She is not really happy with her situation. The physician did not address the pharmacist recommendation to taper the dose of fluoxetine -9/9/15: She is alert, again weepy, anxious, agitated. Impression: progressive age-related and also vascular dementia, I think now with some confusion, some paranoid thought, some emotional lability. The physician did not provide a rationale for increasing fluoxetine from 20 mg to 40 mg daily. -11/11/15: She continues to be somewhat agitated. Medications are reviewed. She has been on fluoxetine 40 mg after her stroke. No further documentation regarding use of fluoxetine 40 mg daily. -1/13/16: voiced some increased anxiety. I think she would probably do better if we could find some task or duty that she could do, give her some value and in summary positive reinforcement. I encouraged staff to get her involved in activities. No further documentation regarding use of fluoxetine 40 mg daily. On 2/9/2016, at 10:54 a.m. RN-I confirmed R75 refused her fluoxetine and stated R75 had refused her fluoxetine the past 5 days. RN-F stated she had contacted the physician regarding the medication refusal. RN-F also stated R75's mood had been stable and she had been out of her room more since refusing the medication.	F 428		

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F 428	Continued From page 126 However, she had been somewhat more suspicious of staff. On 2/9/2016, at 2:05 p.m. R75 stated she was feeling much better. R75 stated her prescription for depression had been increased awhile ago but she didn't like how it made her feel. R75 stated she stopped taking it a few days ago and has felt better since then. R75's affect was bright and smiling. R75 stated she felt like a new person. On 2/9/2016, at 2:38 p.m. RN-F confirmed R75 was on fluoxetine when she was admitted to the facility over a year ago and a tapering of the medication had not been attempted. RN-F stated R75 had actually had an increase in the dosage of medication and verified there had not been a documentation of the rationale for the increase nor documentation of a contraindication for an attempted decrease of the medication. RN-F stated R75's mood had been more stable since refusing the medication. On 2/9/2016, at 2:58 p.m. RN-F stated after the pharmacist had reviewed the residents' medications she was emailed a list of his recommendations. RN-F indicated she would have expected the pharmacist to have requested a rationale for the increased dose of fluoxetine. Attempts to contact the consultant pharmacist were unsuccessful on 2/9/16 and 2/10/16. Medication Administration Record policy dated	F 428		

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F 428	Continued From page 127 3/1/14, indicated all medications would have a specific reason for use. Unnecessary Drugs-Antipsychotic Drugs policy dated 4/2009, indicated psychotropic drug therapy should only be used when necessary to treat a specific condition as diagnosed and documented in the clinical record. In addition, prior to the administration of a PRN antipsychotic, justification of use must be documented in the medical record which included reasons why the medication was given and what nonpharmacological interventions were tried prior to administration	F 428		
F 431 SS=E	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 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	F 431		3/21/16

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F 431	Continued From page 128 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 consistently contained a label to ensure safe administration on 3 of 8 medication carts. In addition the facility failed to consistently ensure medications with a shortened expiration date after opening were labeled with the date the medication was opened on 4 of 8 medication carts. Findings include: During observation of the west Birch medication cart on 2/4/16, at 2:13 p.m. with registered nurse (RN)-C two, in use, Advair Diskus inhalers lacked resident labels to identify resident name, pharmacy information, medication, directions for use and date filled. Both Advair Diskus' lacked a date when they were opened. In addition one Symbicort inhaler was not dated when opened and had a fill date of 8/21/15. RN-C stated the	F 431	All medication carts have been audited to assure all medications are properly labeled. All medications with shortened expiration dates after opening are labeled with the date the medication was opened. Re-education has been provided to all nurses and TMA□s of proper labeling. All resident may be affected when the medication is not labeled or labeled with expiration dates, but none show any negative outcome. Medication audits completed weekly X 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 431	Continued From page 129 Advair come in a bag or box with the label attached but did not know where the bag/box for the medication was located. When interviewed on 2/4/16, at 2:19 p.m. RN-F verified Symbicort expired three months after opening and the Advair Diskus should have been stored with packaging that included the prescription label. During observation of the Willow medication cart on 2/4/16, at 3:02 p.m. with licensed practical nurse (LPN)-E one Flovent inhaler lacked a resident label to identify resident name, pharmacy information, medication, directions for use and date filled. LPN-E verified the Flovent did not have a label attached and the packaging for the medication was not on the cart. During observation of the east Cedar medication cart on 2/5/16, at 8:56 a.m. with trained medication assistant (TMA)-A one, in use, Symbicort inhaler was not dated when the medication was opened. The fill date for the Symbicort was 9/15/15. TMA-A verified the Symbicort was not dated when the medication was opened. During observation of the west Cedar medication cart on 2/5/16, at 9:05 a.m. with LPN-D one Novolog Flex Pen (insulin medication to control diabetes) was found to have a torn label and could not identify resident name, pharmacy information, medication, directions for use and date filled. The Novolog Flex Pen also lacked a	F 431		

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F 431	Continued From page 130 date in which the insulin pen was opened. In addition another Novolog Flex Pen with a fill date of 10/17/15, was opened and lacked a date when the medication was opened. LPN-D verified both Novolog flex pens were opened and lacked documentation when the insulin was opened and one Novolog Flex Pen's label was torn off. The manufacturers package insert for Advair Diskus directed to throw away Advair Diskus in the trash one month after opening. The manufacturers package insert for Symbicort directed to throw away Symbicort when the counter reached zero or three months after opening. The manufacturers package insert for Novolog flex pen directed to dispose of the pen 28 days after opening. When interviewed on 2/05/16, at 2:21 p.m. the director of nursing stated medications are to be stored with their label and medications with an expiration date after opening were to be dated when opened. The facility's policy Medication Labeling dated 3/1/14, included labels are to include the resident's name, drug name, dose, frequency, route instructions for use and expiration date.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		3/21/16

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F 441	Continued From page 131 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 132 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control program which included consistent monitoring, trending, and analysis of infections to reduce the potential transmission to other residents in the facility. This had the potential to affect all 140 residents residing in the facility. In addition, the facility failed to ensure proper hand washing was completed for 1 of 1 resident (R183) who was observed to received wound care and for 1 of 8 residents (R68) who was observed to receive personal cares. Findings include: The facility infection control tracking sheets were reviewed from 11/2015, through 1/2016, and revealed the facility resident units were tracked on different tracking sheets. The individual unit sheets contained the following information: The facility Monthly Infection Report identified the following to be tracked for resident infections: - Name/Room - Admit Date - M.D. - Site - Cath SP or INDW [catheter, suprapubic or indwelling] - 3 Symptoms - Culture Date - Cultures results/ Organism, Colony Count - Med Ordered - Started Med	F 441	Resident 183 and Resident 68 has not shown any ill effects from this practice. An Infection control program has been developed and initiated to monitor and analysis for any trends or patterns of infections to reduce the potential transmission to other residents. This has the potential to affect all residents, but none show any negative outcome. Re-education has been provided to nursing staff on infection control surveillance, monitoring and trending of infections, and hand hygiene. Infection control and hand hygiene audits will be completed weekly x 3 months and then reevaluated by QAA. DON or designee will report results and trends to the QAA monthly and follow up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 441	Continued From page 133 - Stopped Med - Resolved - Ongoing The facility form Infection Tracking Log identified the following to be tracked for resident infections: - Date - Name - Unit/Room - Signs/ Symptoms - Onset Date - Culture Site - Culture Date - Culture Result - Infect or Colon [infection of colonized] - Isolation Precautions yes or no - Start Date - D/C Date [discontinued date] The November 2015, logs identified 35 resident infections. The logs did not consistently identify the signs and symptoms, documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, type or location of the unidentified infections and culture dates. The logs did not identify if the infections were community acquired or healthcare associated. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents. The December 2015, logs identified 51 resident	F 441		

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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 134 infections. The logs did not consistently identify resident room numbers,signs and symptoms, documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, type or location of the unidentified infections and culture dates. The logs did not consistently identify if the infections were community acquired or healthcare associated. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents. The January 2016, logs identified 35 resident infections. The logs did not consistently identify resident room numbers, signs and symptoms, documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, type or location of the unidentified infections and culture dates. The logs did not consistently identify if the infections were community acquired or healthcare associated. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents. The February 2016 logs were unavailable for review.	F 441		

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	245366	A. BUILDING _____ B. WING _____	02/10/2016

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F 441	Continued From page 135 When interviewed on 2/5/16, at 2:26 p.m. the director of nursing verified the units had not consistently documented on the same form with all the required information or obtained all the needed information for the tracking, monitoring and canalizing of infections. A policy on the facility's infection control program tracking, monitoring and analysis was requested but not provided. R183 was observed to receive wound care services and the staff failed to ensure appropriate hand washing techniques were followed. On 2/3/16, at 10:56 a.m. licensed practical nurse (LPN)-D and nurse practitioner (NP)-A were observed to complete R183's wound care on R183's three pressure ulcers. LPN-D gathered supplies and with NP-A entered R183's room. R183 was lying in bed. NP-A and LPN-D washed their hands and NP-A donned a pair of gloves. LPN-D uncovered R183's feet and placed clean hand towels on the bed next to R183's feet along with skin barrier single use wipes and povidone-iodine disposable swabs. LPN-D removed the blue foam boot from R183's right foot and NP-A held R183's right foot off of the bed while LPN-D donned a pair of gloves. R183's right heel wound had no dressing on it. LPN-D measured the wound, cleansed the wound with normal saline, and patted the wound dry with a gauze pad. R185's right heel wound measured 2.7 centimeters (cm) in length by 2.8 cm in width and was unstageable (wound with full thickness tissue loss in which the base of the ulcer is completely covered with slough (dead tissue) or	F 441		

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eschar (dry dark scab) in the wound bed). LPN-D removed her gloves and immediately donned a new pair of gloves. LPN-D applied skin barrier to the right heel wound, let it dry, and then painted the wound with the povidone-iodine swab. LPN-D removed her gloves and placed the foam boot back on R183's right foot. LPN-D proceeded to remove the foam boot on R183's left foot. R183's left heel wound had no dressing on it. LPN-D donned a new pair of gloves, irrigated the wound with normal saline, patted down the wound dry with a clean gauze pad and removed her gloves. LPN-D measured R183's left heel stage 2 wound to be 2.1 cm by 3 cm. LPN-D painted the wound with the povidone-iodine swab, removed the glove from her left hand, and then used her gloved hand to place the barrier wipe. LPN-D removed the remaining glove on her right hand and replaced the foam boot on R183's left foot. NP-A assisted LPN-D in assessing the wounds and elevated R183's feet during the wound care. LPN-D went into R183's bathroom and washed her hands. Registered nurse (RN)-B entered the room, washed her hands and donned a pair of gloves. LPN-D donned a new pair of gloves, gathered the soiled gloves and supplies from the window sill, placed them in the garbage, removed her gloves, and washed her hands. LPN-D donned a new pair of gloves, while NP-A and RN-B positioned R183 on his left side. LPN-D removed R183's dry brief and removed the dressing on R183's coccyx. LPN-D removed her gloves, immediately donned a new pair of gloves and measured R183's stage 2 coccyx wound to be 1.5 cm by 1.2 cm. LPN-D then irrigated the wound with normal saline, removed her gloves, donned a new pair of gloves, patted the coccyx wound dry with a gauze pad, and removed her gloves. LPN-D donned a new pair of gloves,

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applied the skin barrier wipe on the wound, and removed her gloves. Then using her bare hands placed a foam dressing over the coccyx wound. LPN-D, NP-A and RN-B removed their gloves and washed their hands.

On 2/3/16, at 11:32 LPN-D confirmed she had not washed her hands after removal of her gloves and between the wound cares on R183's heels, in addition she had not washed her hands following the removal of the soiled dressing on R183's coccyx area and had used her bare hand and applied the foam dressing to R183's coccyx wound. LPN-D stated she should have washed her hands. RN-B and NP-A did not disagree with this observation nor the need for LPN-D to wash her hands after the removal of gloves and in between wound care between wounds.

The facility's Procedure for Clean Dressing Technique (undated) directed staff to wash their hands or use an alcohol based hand rub during wound care after each glove removal.

R68 was observed receiving personal cares on 2/3/16, and staff did not performed appropriate hand washing techniques.

On 02/03/2016, at 7:59 a.m. nursing assistant (NA)-D was observed to enter R68's room, raise the bed to a working height and uncovered R68 to get him up for the day. R68 was observed dressed in a shirt and incontinent brief. NA-D donned clean gloves and removed R68's incontinent brief which was wet. NA-D washed R68's groin utilizing a wipe and then rolled R68 to

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his right side and washed his bottom. A smear of feces was cleaned from R68's rectum. NA-D discarded the soiled brief and wipe into the garbage, applied a clean brief and assisted R68 into pants, socks and shoes. NA-D removed and discarded her gloves and placed a mechanical lift sling under R68. NA-E entered the room with a mechanical lift and NA-D and NA-E attached the lift sling to the lift and transferred R68 to a wheelchair. NA-D removed the lift sling and attached a clip alarm to R68's chair and the back of his shirt. NA-D then placed R68's glasses on his face and without performing hand hygiene gathered supplies, placed toothpaste on a toothbrush and brushed R68's teeth. NA-D gave R68 a sip of water to rinse his mouth and put away the supplies. She then bagged the garbage, brought it to the soiled utility room and washed her hands.

On 02/03/2016, at 1:49 p.m. NA-D confirmed she had not performed hand hygiene after peri cares and prior to oral cares and should have done so.

On 02/05/2016, at 11:15 a.m. the DON confirmed hand hygiene should have been performed after peri cares and prior to oral cares.

The Hand Washing policy dated 4/1/2008, indicated the facility required staff to wash their hands after each direct resident contact for which hand-washing was indicated by accepted professional practice. The policy also directed hand-washing was to be conducted as per recommendations from the Center for Disease Control guidelines.

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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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the kitchen in a clean and sanitary manner. In addition, the facility failed to ensure an electric wheelchair was in good repair for 1 of 1 resident (R133) who utilized an electric wheelchair. Findings include: On 2/1/16, at 4:02 p.m. an initial tour of the kitchen was done with the dietary director (DD). On 2/3/16, at 1:27 p.m. a revisit tour was also conducted with the DD and the corporate consultant (CC)-B and the following concerns were observed: -The floor around the large floor mixer was rusty with debris and black grime around the bottom of the mixer stand. The DD stated the area would be cleaned right away. -The large stove and ovens had grease and black grime build up around the outer edges of ovens, on the stove. The triple stacked ovens had greasy, sticky grime build up on the doors and handles. The glass windows were dirty with food spills. The DD stated staff only used the upper	F 465	The facility has cleaned all areas in the kitchen including: stove and ovens, Cooler #5, toaster, the 4 double door dry storage cabinets, range hood, fruit and vegetable prop counter, timer knobs, shelf the microwave sits on, and wall pillar. All residents that have food prepared in this facility have the potential to be affected by this practice, but none show any negative outcome. A cleaning schedule has been developed and adopted into practice. A new policy and procedure has been developed and adopted into practice. Kitchen cleaning audits will be conducted weekly x 3 months and then reevaluated by QAA. The Dietary manager or designee will report results and trends of all audits to the QAA and follow up as needed. Resident 133 scooter has been assessed and an appropriate cover has been applied until the new seat that has been ordered, arrives. Other residents with electric scooters have had their scooters assessed to ensure in good repair. Electric Scooter audits will be conducted weekly x 3 months and then reevaluated	3/21/16

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F 465	Continued From page 140 and lower oven as the middle oven was out of order and had been for a long time. -The kitchen floor had food debris, the outer edges of the entire perimeter of the kitchen and around all equipment and storage areas including the food prep area were observed to dirty with black, thick substances built up. The DD verified the floors were dirty with build up and it was not clean. -Cooler #1- the floor was dirty with a black grimy substance. The DD stated this would be mopped and cleaned at the end of the day. -Cooler #5- milk storage, there were dried white milk spills on the inside door and the walls on the left upon entering had milk spills. The DD verified the area was not clean. -The large commercial toaster on the bread and sandwich station counter had sticky, grime build up. The DD verified the side and front of the toaster was not clean. -The 4 double door dry storage cabinets doors/handles had black, grime substance on them. The DD stated she would have them cleaned. -The range hood above the cook stove has three panels which had dust and debris build up. The DD stated this was scheduled to be cleaned shortly as it was usually done every two weeks. -The fruit and vegetable prep counter cabinets had black grime on the doors and handles and dirty tape residue. The old cooler below the counter for the salad cold food prep area, was	F 465	by QAA. Maintenance Director or designee will report results and trends of all audits to the QAA and follow up as needed. It is the responsibility of the Administrator or designee to ensure compliance.	

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dirty with food debris, grime and rust. The cabinet and the doors were off and the side shelves were used for large can storage. The DD verified the areas were not clean and she was not sure what happened to the cabinet doors.

-The timer knobs for the Steamcraft ultra steamer which was used for cooking, were missing. The DD stated staff just used the manual switch and would frequently check the foods as they were unable to set the timer knobs. The DD stated the knobs had been broken for over a year and she was unsure of what the plan was for the steamer as the knobs may have been too costly to replace.
The DD verified walls by steamer and stove were dirty with grime, dust and food debris. The DD verified the Vulcan convection oven had grime built up on doors handles and knobs.

-The DD verified all of the garbage/trash receptacles had built up food debris and grime on them and were in need of cleaning.

-The shelf the microwave sat on was missing laminate on the left/right side which had a sticky substance on edges of shelf where laminate was.

-The wall pillar between the dirty dish and clean dish area had a two foot by three foot section of peeling paint. The DD verified this should have been taken care of.

On 02/03/2016, at 10:59 a.m. CC-B stated the kitchen was on the facility's remodel list to be completed after the remodeling of resident rooms was completed. The CC-B agreed the kitchen needed to be cleaned and stated staff would be

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F 465	Continued From page 142 getting the aforementioned areas cleaned up right away. CC-B added, just because the kitchen was old, it did not have to be dirty. On 02/03/2016, at 1:35 p.m.. the DD verified all of the aforementioned areas and equipment were not clean and sanitary. The DD stated they had cleaning schedules and assignments set up and staff coming in tonight to clean the equipment and areas. The DD stated she was aware of the plan to update of the kitchen but was just was not sure when. The DD stated the kitchen did not have anyone specific to do deep cleaning rather was completed daily, after us. The DD stated maintenance and housekeeping were involved with night cleaning. The DD stated staff needed to do a better job of cleaning. The Department of Dietary - Department Cleaning Policy, updated 3/25/14, indicated the equipment, storage and work areas in the dietary department would be kept clean and safe for food handling, preparation and service. R133's electric wheelchair was not maintained in good repair. On 02/02/2016, at 09:10 a.m. R133's electric wheelchair was observed. The hard plastic control panel, located on the right arm of the wheelchair, was scraped, marred and pock-marked for approximately 3 inches along the right outer edge. The right upper surface of the control panel was smudged with white ash. The head rest was covered with black	F 465		

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F 465	Continued From page 143 duct tape along the side edges, top edge and posterior surface. The back cushion was covered with black duct tape along the entire sides of the cushion from approximately 2 inches above the arm rest to the head rest. The posterior of the back cushion was covered in 4 strips of black duct tape placed side by side starting at the edge of the chair and covering the surface of the cushion to the head rest, on both sides. The left corner of the seat cushion had an approximate 1 inch cut in the covering, exposing the inner foam cushion. On 02/09/2016, at 2:48 p.m. registered nurse (RN)-F stated R133 resident had talked to her about needing a new chair. RN-F stated R133 was worried about the financial aspect of obtaining a new chair but was unaware if social services was working with her regarding the chair. RN-F indicated repairs for a wheel were made last week, however verified there was no chair on order. RN-F stated R133's chair was pretty banged up and dinged up. RN-F confirmed the back and head rest cushions were covered in duct tape. and the control panel on the right arm rest was nicked and marred. On 02/9/16, at 5:07 p.m. the maintenance director(MD) stated the maintenance department was responsible for maintaining residents' wheelchairs. MD confirmed they had applied the duct tape to R133's wheelchair and stated they probably needed to do it again. No policy regarding wheelchair maintenance was provided.	F 465		

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F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure nursing assistants had at least 12 hours of continuing education annually for 6 of 6 nursing assistant (NA-V, NA-W, NA-X, NA-Y, and NA-Z) personnel records reviewed. This had the potential to affect all 140 residents who resided at the facility. Findings include: Records provided indicated the facility provided annual training which included Infection control for Tuberculosis, Fire Safety, Environmental safety, Client Behaviors and Caring for the Alzheimer's Resident. There were unit specific training's that occurred throughout the 2015, calendar year.	F 497	Education program has been developed and initiated to assure all nursing assistants have 12 hours of in-service annually. Those employees, who did not have 12 hours of in-service, have received additional education so that they are current and up to date with a total of 12 hours of in-service. All residents have the potential to be affected related to nursing assistants not receiving 12 hours of education, but none show any negative outcome. In-service audits completed monthly x 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow up as needed.	3/21/16

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F 497	Continued From page 145 On 2/9/16, at 11:00 a.m. the director of human resources stated the facility kept track of nursing assistant ongoing education on a calendar year system. However, the director of human resources stated the employee continuing education records had not been kept current because there wasn't anyone appointed to keep track of the training records until the first week in February 2016. Six nursing assistant employee training records were reviewed to determine if each nursing assistant employed longer than 1 year had 12 hours of ongoing training annually and the following was revealed: NA-U was hired in 9/3/10, and had received a total of 1 continuing education hour for the 2015, calendar year. NA-V was hired on 11/1/09, and had received a total of 5 continuing education hour for the 2015, calendar year. NA-W was hired on 8/28/13, and had received a total of 11 continuing education hour for the 2015, calendar year. NA-X was hired on 9/3/10, and had received a total of 5 continuing education hour for the 2015, calendar year. NA-Y was hired on 5/19/14, and had received a total of 6 continuing education hour for the 2015, calendar year. NA-Z was hired on 6/23/14, and had received a total of 4 continuing education hour for the 2015, calendar year.	F 497	It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 497	Continued From page 146 On 2/9/16, at 1:30 p.m. the director of human resources confirmed the aforementioned nursing assistants had not completed the required 12 hours of continuing education in the 2015, calendar year. A policy regarding ongoing nursing assistant training was requested, however had not been provided.	F 497		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow through with laboratory orders for 2 of 6 residents (R8, R75) reviewed for laboratory services. Findings include: R8 did not have laboratory tests completed as ordered the by physician. R8's face sheet (form with diagnoses and demographic information) dated 10/2/15, indicated R8 had diagnoses which included paranoid schizophrenia, hypothyroidism, dementia, weakness, acute kidney failure and	F 502	Residents 8 and 75□s charts have been reviewed and missed labs have been ordered and followed through Education to Unit Managers, nurses and HUC□s have been provided on follow through with lab orders and the policy and procedure for lab draws All residents that depend on staff to follow through with MD lab orders have the potential to be affected, but none show any negative outcome. A new process for monitoring of labs has been implemented. Lab audits completed weekly x 3 month and then reevaluated by QAA. DON or designee will report results and trends of all audits to the QAA and follow	3/21/16

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	245366	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

(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 502	Continued From page 147 Alzheimer's disease. R8's Physician's Orders dated 1/11/16, indicated nurse practitioner (NP)-A ordered the following laboratory work to be completed: -Lipid profile (blood test to check for broad abnormalities in lipids such as cholesterol and triglycerides) -Thyroid-stimulating hormone (TSH) (blood test to check for thyroid abnormalities) -Complete blood count (CBC) (blood test to evaluate overall health and detect disorders like anemia or infection) -Renal/hepatic profile (blood test to detect kidney and liver functions) R8's Dietary Progress Notes dated 1/26/15, indicated R8 had no recent labs to review. On 2/4/16, at 9:04 a.m. health unit coordinator (HUC)-A confirmed R8's lab orders on 1/11/16, however no laboratory results were found in R8's medical record, nor HUC-A's loose papers to be filed. HUC-A confirmed these results should have been in R8's medical record. HUC-A stated sometimes R8 refused to have lab work drawn, however if R8 refused, the nursing staff should have written a progress note which indicated R8 had refused. HUC-A verified R8's lab work had been ordered through Essentia Laboratories. HUC-A stated Essentia Laboratory didn't come every day, however R8 was on the facility's calendar to have lab work drawn on 1/13/16.	F 502	up as needed. It is the responsibility of the Director of Nursing or designee to ensure compliance.	

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F 502	Continued From page 148 On 2/4/16, at 2:49 p.m. registered dietician (RD)-A confirmed R8's lab results would have been very important to RD-A as she conducted R8's 1/26/16, nutritional review. On 2/4/16, at 2:49 p.m. registered nurse (RN)-B confirmed NP-A had written an order on 1/11/16, for R8 to have a lipid profile, TSH, CBC and renal/hepatic profile. RN-B verified R8's medical record lacked the results of these lab tests, documentation of why they had not been completed and notification to NP-A that the ordered lab tests had not been completed. RN-B confirmed all of this should have been completed and documented in R8's medical record. On 2/5/16, at 8:15 a.m. the director of nursing (DON) confirmed it was her expectation for staff to follow through on provider orders, or when unable to follow through, to notify the ordering provider and this should all be documented in the resident's medical record. R75 did not have laboratory tests performed as ordered by the physician. R75's quarterly Minimum Data Set (MDS) dated 12/23/15, indicated R75 was cognitively intact and had diagnoses which included hypertension, hyperlipidemia and stroke. R75's Patient Letter from the physician dated 8/20/15, provided results of recent laboratory tests which included a CBC, comprehensive metabolic panel (a blood test that measures your sugar (glucose) level, electrolyte and fluid	F 502		

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F 502	Continued From page 149	F 502		

balance, kidney function, and liver function. Glucose is a type of sugar your body uses for energy. Electrolytes keep your body's fluids in balance), vitamin B12 (measures the amount of B12 in the blood) and TSH. The physician included an interpretation of the results and recommended getting a folic acid level (a test primarily used in the diagnosis of megaloblastic anemia - a blood disorder in which the number of red blood cells is lower than normal.) because R75 was anemic and because there had been some cognitive dysfunction. Additionally, he recommended a serum protein electrophoresis (test measures specific proteins in the blood to help identify some diseases) and serum for light chain immunoglobulins (test to help detect, diagnose, and monitor plasma cell disorders) because of anemia.

On 02/05/2016, at 2:31 p.m. RN-F confirmed the physician had requested additional lab testing via patient letter on 8/20/15, but was unaware if the testing had been performed. RN-F indicated she would need to follow up with the laboratory.

On 02/09/2016, at 2:35 p.m. RN-F confirmed the lab orders were missed and should have been performed in August. RN-F indicated she had been in contact with the physician who had reordered the tests on 2/8/16. RN-F indicated R75 was scheduled for a laboratory draw for the tests on 2/12/16.

Laboratory Services policy dated 4/1/08, indicated the facility monitored and maintained the quality and timeliness of laboratory services.

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F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee effectively monitored action plans to ensure ongoing complaince was maintained related to repeat quality deficiencies. This failure resulted in an immediate jeapardy for R180 who had fallen and sustained neck fracures. The IJ was removed on 2/5/16, at 2:05 p.m., however, non-compliance	F 520	Residents 156, 180 and 183 have had no ill effect from this practice. Education has been provided to the management staff of QAPI, to include effective action plans, and monitoring of action plans to ensure no repeat deficient practice occurs. QAA committee will review all audits for falls, pressure ulcers and the restorative	3/21/16

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F 520	Continued From page 151 remained at a scope and severity level of G, which indicated actual harm for R180 due to a neck fracture sustained during a fall which required medical interventions. In addition, this failure resulted in harm for R156 related to a decline in ambulation and R183 who developed three pressure related ulcers following admission to the facility. This had the potential to affect all 140 residents who resided in the facility. Findings include: Refer to F282: The facility failed to provide services in accordance with the resident's written care plan for 1 of 3 residents (R183) who required every one hour repositioning assistance and was observed to not receive the assistance. Refer to F309: The facility failed to perform neurological assessments following a fall as directed by facility policy for 1 of 1 resident (R180) who had fallen and sustained head and neck injuries and required neurological checks. Refer to F314: The facility failed to complete a timely comprehensive assessment following the identification of a stage two pressure ulcer in order to prevent and / or promote the healing of pressure ulcers and failed to provide every one hour turning and repositioning as directed by the care plan for 1 of 3 residents (R183) admitted with intact skin who developed three stage two pressure related ulcers following admission to the facility. This resulted in actual harm to R183.	F 520	program for tracking and trending and make appropriate recommendations. Education to staff on QAPI has been completed. QAA will be conducted weekly x 3 months. QA audits will be completed weekly x 3 months and then reevaluated by QAA. The administrator or designee will report results and tends of all audits to the QAA and follow up as needed. It is the responsibility of the Administrator or designee to ensure compliance. Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is	

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F 520	Continued From page 152 Refer to F323: The facility failed to conduct ongoing comprehensive fall assessments to determine causal factors for 1 of 1 resident (R180) with a history of falls and continued pattern of self transfers and ambulation. This failure resulted in an immediate jeopardy (IJ) due to R180 sustaining cervical (neck) fractures as a result of a fall on 2/2/16. This IJ In addition, the facility failed to implement their smoking policy related to safe smoking practices and / or the safe storage of tobacco products and fire materials for 2 of 2 residents (R136, R95) observed to have their smoking and fire materials unsecured or unsafely extinguishing / disposing of the cigarettes. On 2/9/16, at 3:44 p.m. the administrator stated the facility had completed routine audits and had routine discussions related to the past survey findings. He stated the facility had conducted monthly QAA meetings to maintain and ensure compliance of the federal deficiencies sited during the last fiscal year survey on 5/20/15, and subsequent return visits on 7/21/15, and 9/10/15. The administrator verified the facility had not developed or implemented new action plans to address the identified concerns rather the QAA team continued to work off of the previous survey years plan of correction. The undated Quality Assurance and Performance improvement Program policy directed the QAA committee to assume responsibly for the services of the community / facility related to the quality of care, quality of life, safety, customer satisfaction, regulatory, compliance and congruous quality	F 520	submitted as the facility□s credible allegation of compliance.	

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F 520	Continued From page 153 improvement opportunities.	F 520		

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/02/2016**

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CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD** **DULUTH, MN 55811**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2016

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

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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail 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. Chris Jensen Health and Rehabilitation Center is a 2-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 85 an addition(s) was constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000		

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K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 170 beds and had a census of 165 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT met.	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 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 could affect the residents, visitors, and staff members of the facility. Findings include:	K 056	The automatic sprinkler system has been updated to meet the NFPA 13 Standard for the Installation of Sprinkler Systems by Viking Automatic Sprinkler Co. on 3/3/16. Mike Smith or designee will be responsible to monitor to prevent a reoccurrence of the deficiency.	3/29/16

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K 056	Continued From page 3 On facility tour between 1:00 PM to 5:00 PM on 02/02/2016, observations have revealed that there is a quick response sidewall sprinkler head that is located under the garage door rail and a standard sprinkler head that is approximately 6 feet away in the same smoke compartment. This deficient condition was verified by the Maintenance Supervisor.	K 056		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 1:00 PM to 5:00 PM on 02/02/2016, during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire sprinkler system out of service policy.	K 154	A Fire Protection Systems Out of Service Policy has been developed and has been implemented The actual date of completion for writing the policy was 2/2/16. Education of this policy will be completed by 3/29/2016 Mike Smith or designee will be responsible to monitor to prevent a reoccurrence of the deficiency.	3/29/16

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K 154	Continued From page 4 This deficient condition was verified by the Maintenance Supervisor.	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 1:00 PM to 5:00 PM on 02/02/2016, during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient condition was verified by the Maintenance Supervisor.	K 155	A Fire Protection Systems Out of Service Policy has been developed and has been implemented The actual date of completion for writing the policy was 2/2/16. Education of this policy will be completed by 3/29/2016 Mike Smith or designee will be responsible to monitor to prevent a reoccurrence of the deficiency.	3/29/16

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 29, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5366026, H5366066

Dear Ms. Porter:

The above facility was surveyed on February 1, 2016 through February 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5366066. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burk at (218) 308-2104 or 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
	00598	A. BUILDING: _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 1, 2, 3, 4, 5, 8, 9, 10, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee effectively monitored action plans to ensure ongoing complaince was maintained related to repeat quality deficiencies. This failure resulted in an immediate jeapardy for R180 who had fallen and sustained neck fracures. The IJ was removed on 2/5/16, at 2:05 p.m., however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R180 due to a	2 255	Corrected	3/29/16

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2 255	Continued From page 3 neck fracture sustained during a fall which required medical interventions. In addition, this failure resulted in harm for R156 related to a decline in ambulation and R183 who developed three pressure related ulcers following admission to the facility. This had the potential to affect all 140 residents who resided in the facility. Findings include: Refer to F282: The facility failed to provide services in accordance with the resident's written care plan for 1 of 3 residents (R183) who required every one hour repositioning assistance and was observed to not receive the assistance. Refer to F309: The facility failed to perform neurological assessments following a fall as directed by facility policy for 1 of 1 resident (R180) who had fallen and sustained head and neck injuries and required neurological checks. Refer to F314: The facility failed to complete a timely comprehensive assessment following the identification of a stage two pressure ulcer in order to prevent and / or promote the healing of pressure ulcers and failed to provide every one hour turning and repositioning as directed by the care plan for 1 of 3 residents (R183) admitted with intact skin who developed three stage two pressure related ulcers following admission to the facility. This resulted in actual harm to R183. Refer to F323: The facility failed to conduct ongoing comprehensive fall assessments to determine causal factors for 1 of 1 resident	2 255		

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2 255	Continued From page 4 (R180) with a history of falls and continued pattern of self transfers and ambulation. This failure resulted in an immediate jeopardy (IJ) due to R180 sustaining cervical (neck) fractures as a result of a fall on 2/2/16. This IJ In addition, the facility failed to implement their smoking policy related to safe smoking practices and / or the safe storage of tobacco products and fire materials for 2 of 2 residents (R136, R95) observed to have their smoking and fire materials unsecured or unsafely extinguishing / disposing of the cigarettes. On 2/9/16, at 3:44 p.m. the administrator stated the facility had completed routine audits and had routine discussions related to the past survey findings. He stated the facility had conducted monthly QAA meetings to maintain and ensure compliance of the federal deficiencies sited during the last fiscal year survey on 5/20/15, and subsequent return visits on 7/21/15, and 9/10/15. The administrator verified the facility had not developed or implemented new action plans to address the identified concerns rather the QAA team continued to work off of the previous survey years plan of correction. The undated Quality Assurance and Performance improvement Program policy directed the QAA committee to assume responsibly for the services of the community / facility related to the quality of care, quality of life, safety, customer satisfaction, regulatory, compliance and congruous quality improvement opportunities. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the	2 255		

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2 255	Continued From page 5 pertinent policies and procedures for ensuring compliance of regulatory requirements. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 255		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure nursing assistants had at least 12 hours of continuing education annually for 6 of 6 nursing assistant (NA-V, NA-W, NA-X, NA-Y, and NA-Z) personnel records reviewed. This had the potential to affect all 140 residents who resided at the facility.	2 285	Corrected	3/29/16

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2 285	Continued From page 6 Findings include: Records provided indicated the facility provided annual training which included Infection control for Tuberculosis, Fire Safety, Environmental safety, Client Behaviors and Caring for the Alzheimer's Resident. There were unit specific training's that occurred throughout the 2015, calendar year. On 2/9/16, at 11:00 a.m. the director of human resources stated the facility kept track of nursing assistant ongoing education on a calendar year system. However, the director of human resources stated the employee continuing education records had not been kept current because there wasn't anyone appointed to keep track of the training records until the first week in February 2016. Six nursing assistant employee training records were reviewed to determine if each nursing assistant employed longer than 1 year had 12 hours of ongoing training annually and the following was revealed: NA-U was hired in 9/3/10, and had received a total of 1 continuing education hour for the 2015, calendar year. NA-V was hired on 11/1/09, and had received a total of 5 continuing education hour for the 2015, calendar year. NA-W was hired on 8/28/13, and had received a total of 11 continuing education hour for the 2015, calendar year.	2 285		

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2 285	Continued From page 7 NA-X was hired on 9/3/10, and had received a total of 5 continuing education hour for the 2015, calendar year. NA-Y was hired on 5/19/14, and had received a total of 6 continuing education hour for the 2015, calendar year. NA-Z was hired on 6/23/14, and had received a total of 4 continuing education hour for the 2015, calendar year. On 2/9/16, at 1:30 p.m. the director of human resources confirmed the aforementioned nursing assistants had not completed the required 12 hours of continuing education in the 2015, calendar year. A policy regarding ongoing nursing assistant training was requested, however had not been provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to the required nursing continuing education to ensure the required nursing assistant education is completed. Education could be provided to staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 285		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review	2 550		3/29/16

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2 550	Continued From page 8 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately reflect limitations in range of motion on the quarterly Minimum Data Set (MDS) for 1 of 3 residents (R52) observed with limitations in range of motion. Findings include: R52's quarterly MDS dated 1/17/16, indicated R52 had no impairment for functional limitation for range of motion (ROM) on upper (shoulder, elbow, wrist, hand) or lower (hip, knee, ankle, foot) extremities. R52's physician progress note dated 1/13/16, indicated R52's diagnoses included cerebral vascular accident (stroke) and left contracture. In addition, the physical exam indicated R52's left upper extremity had a flexion deformity and the shoulder on the left had little movement. R52's care plan dated 11/5/15, indicated under the focus areas of activities of daily living and pain that R52 had a hand contracture.	2 550	Corrected	

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2 550	Continued From page 9 On 2/1/16, at 7:30 p.m. R52 was observed lying in bed with a lamb's wool covered splint on the left hand. R52 stated she wore the splint all the time. R52's Occupational Therapy (OT) Initial Evaluation dated 12/16/15, indicated R52 had a contracture in her left hand. In addition, R52's ROM in her left upper extremity (shoulder, elbow/forearm, wrist and hand) were all impaired. On 2/4/16, at 10:33 a.m. certified occupational therapy assistant (COTA)-A confirmed R52 had worn a palm protector and splint on the left hand for at least six months. COTA-A verified R52 currently had a left hand contracture. On 2/4/16, at 11:20 a.m. registered nurse (RN)-G confirmed R52's quarterly MDS dated 1/17/16, identified R52 as having no upper or lower extremity ROM limitations and stated all other previous MDS reviews had indicated impairment. On 2/4/16, at 1:05 p.m. RN-G verified R52's quarterly MDS dated 1/17/16, inaccurately reflected R52's impairment for functional limitation for ROM on the upper and lower extremities. The Long Term Care Facility Resident Assessment Instrument (RAI) manual dated 10/2015, indicated the three components of the RAI yielded information regarding a resident's functional status, strengths and weaknesses. The MDS included a core set of screening, clinical,	2 550		

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2 550	Continued From page 10 and functional status elements which formed the foundation of a comprehensive assessment for all residents. The primary purpose of the RAI tool was to identify resident care problems that were addressed in the individualized care plan. The RAI directed the assessor to code functional limitation in ROM of A: upper extremity (shoulder, elbow, wrist, hand) or B: lower extremity (hip, knee, ankle, foot) that interfered with daily functions or placed the resident at risk for injury. The assessor was further instructed to code the RAI in the following manner: 0 for no impairment; 1 for impairment on one side; 2 for impairment on both sides. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise the policies and procedures related to the accurate coding of the MDS. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 550		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed	2 555		3/29/16

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2 555	Continued From page 11 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include non-weight bearing status and changes in mode of transfers for 1 of 4 residents (R185) reviewed for accidents. Findings include: On 2/3/16, at 1:20 p.m. R185 was observed in her room, seated in a motorized wheelchair. A nonskid mat was located on the bathroom floor directly in front of the toilet. R185 had nonskid footwear on her left foot and an ace wrapped splint on the right foot/leg. R185's significant change Minimum Data Set (MDS) dated 1/18/16, indicated R185 had no cognitive impairment and required one person assist with bed mobility, transferring and toileting. R185's medical record revealed on 1/29/16, R185 had sustained a fall while self-transferring from the wheelchair to the toilet. The root cause of the fall identified on the IDT Root Cause Review form dated 2/1/16, was R185's foot had fallen asleep	2 555	Corrected	

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2 555	Continued From page 12	2 555		

and that her MS diagnosis had affected R185's foot. R185 was sent to the emergency room for evaluation which determined R185 had suffered a fracture of her right distal fibula (ankle) and R185 had been placed on non-weight bearing restrictions on the right foot.

R185's care plan dated 12/11/15, indicated R185's diagnoses included weakness, multiple scleroses (MS), paralytic gait (a gait deficient noted with leg weakness), and second degree burns on the left foot. The care plan also indicated a focus area for safety due to R185's limited mobility related to MS. The care plan interventions directed staff to assure there was a nonslip mat in R185's bathroom and R185 should wear nonskid footwear. However, R185's care plan lacked indication of R185's non weight bearing status on the right due to the recent fractured right ankle nor provided directive on which assistive transferring device should be used.

R185's nursing assistant (NA) care guide dated 2/3/16, indicated R185 was independent with transfers and lacked indication of R185's non weight bearing status on the right foot.

On 2/3/16, at 1:51 p.m. registered nurse (RN)-B confirmed R185's care plan had not been revised to include the non-weight bearing status and the need to provide additional assistance with transfers.

On 2/3/16, from 3:26 p.m. to 3:50 p.m. NA-J and NA-N were interviewed and both stated they were

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CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

(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
2 555	Continued From page 13 aware of R185's non weight bearing status and stated a sit to stand lift was utilized when R185 needed to be transferred. At the same time, NA-K, NA-L, NA-M and NA-O stated they were not aware of R185's weight bearing status and stated they would follow the direction provided on their care guide (which indicated R185 independently transferred). On 2/4/16, at 8:46 a.m. the director of nursing (DON) confirmed R185's care plan should have been revised to include her non-weight bearing status to promote safe care. The Care Plan-Comprehensive policy dated 4/1/08, directed staff to periodically revise the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise the policies and procedures related to the revision of the care plan. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 555		
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	2 560		3/29/16

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2 560	Continued From page 14 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 observation, interview and document review, the facility failed to develop a care plan which identified smoking and interventions for the safe storage of tobacco products and fire materials for 1 of 2 residents (R95) reviewed for safe smoking. In addition, the facility failed to develop the care plan which included target behaviors and non pharmalogical interventions for 3 of 3 residents (R139, R136, R153) receiving as needed antipsychotic and antianxiety medications. Findings include: R95's utilized smoking materials and her care plan was not developed to identify a smoking plan nor the safe storage of the materials. R95's annual Minimum Data Set (MDS) dated 1/10/16, indicated R95 was cognitively intact, required supervision off and on the unit and had current tobacco use. R95's Smoking Safety Assessment, dated 1/13/16, indicated, R95 was able to move without	2 560	Corrected	

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2 560	Continued From page 15 assistance to / from designated smoking areas, able to use ashtray to self-extinguish cigarettes, could use lighter or matches safely, had history of smoking-related incidents such as burned clothing. Interventions identified R95 was independent with smoking, utilized a smoking apron and was instructed and understood facility smoking policy and was identified on the care plan. R95's Resident Smoking Agreement, dated 6/30/15, indicated, all residents who wish to smoke during their stay will receive a smoking assessment and a signed copy of the smoking guidelines. All smoking materials must be kept secure for the safety of all residents. We recognize there are special circumstances and other options will be designed for individual situations. If the smoking assessment demonstrates the resident is able to safely smoke independently, by meeting all of the conditions described in the assessment, the resident's care plan will be revised to include the resident's wishes to smoke. The signed agreement did not identify any special circumstances. R95's Resident Smoking Guidelines dated 6/30/15, indicated, all smoking materials must be kept secure for the safety of all residents. We recognize there are special circumstances and other options will be designed for individual situations. The Guidelines lacked any special circumstances. On 2/2/16, at 8:24 a.m. R95's over the bed table was observed from the Elm wing hallway outside of R95's room. A tray with one 16 ounce bag of	2 560		

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2 560	Continued From page 16 loose tobacco, a cigarette rolling machine, 20 filtered cigarettes, a purple cigarette box, three cigarette lighters and loose tobacco which covered the tray was observed on R95's overbed table. R95 was not in the facility at this time as had been admitted to the hospital on 1/25/16. On 2/2/16, at 1:35 p.m. R95's over the bed table continued to contain the 16 ounce bag of tobacco, a cigarette roller, the purple cigarette box, 20 filtered cigarettes, and three cigarette lighters. A strong tobacco odor was noted in R95's room. On 2/2/16, at 1:40 p.m. R95 returned from the hospital. On 2/2/16, at 2:13 p.m. R95 stated she rolled her own cigarettes and was heading to the facility smoking area. R95 was observed to put on her jacket, pick up three cigarette lighters and the purple cigarette box and put them into her jacket pocket and left for the smoking area. The bag of tobacco, cigarette roller, 20 cigarettes and loose tobacco remained on the over the bed tray / table. On 2/2/16, at 7:30 p.m. R95 was readmitted to the hospital. On 2/3/16, at 11:28 a.m. R95's smoking products, a 16 ounce bag of tobacco, cigarette rolling machine and loose tobacco were observed on R95's over bed table / tray. Family member (FM)-A stated R95's smoking material was always left out in the open, even when R95 was	2 560		

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2 560	Continued From page 17 not in the facility. FM-A stated R95's room always smelled like tobacco. On 2/3/16, at 3:36 p.m. licensed practical nurse (LPN)-B stated she was not sure what R95's care plan indicated regarding R95's smoking or smoking products or where she was suppose to keep them. LPN-B verified the R95's smoking products, tobacco, roller, cigarettes and loose tobacco were on a tray on the over the bed table in R95's room and not securely stored. LPN-B stated she was not sure what was supposed to be done with them. LPN-B also stated the other resident who smoked on this wing locked them in his in a drawer. LPN-B verified there were residents who had confusion and wandered on the wing. On 2/3/16, at 3:40 p.m. registered nurse (RN)-D stated she did not know what the smoking plan was or how R95's smoking materials were supposed to be secured. RN-D stated she knew when R95 was in the facility, the materials were not secured. On 2/3/16, at 3:44 p.m. the director of nursing (DON) stated she was unsure what R95's smoking plan was and would check the policy and find the information for R95's plan for smoking and storage. The DON verified R95 was readmitted to the hospital last night and was not currently in the facility. The DON stated she would go and put R95's smoking materials away. On 2/3/16, at 5:59 p.m. the DON verified R95's care plan did not reflect a smoking plan. The	2 560		

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2 560	Continued From page 18 DON also verified smoking products should have been secured, especially when a resident was not in the facility. On 2/3/16, at 7:08 p.m. the DON stated R95's care plan should have reflected her smoking plan including tobacco product storage. R139 received as needed (PRN) lorazepam (antianxiety) medication and the facility failed to develop a comprehensive care plan which identified target behaviors and non-pharmacological interventions to be attempted prior to the administration of the medication. R139's Physician Order sheet dated 1/12/16, indicated R139 had diagnoses which included acute confusional state and dementia. The order sheet also indicated R139 was prescribed Seroquel (antipsychotic) 25 mg (milligrams) twice a day and lorazepam (ativan / antianxiety) 0.5 mg 1/2 tablet twice daily, as needed. R139's care plan dated 1/28/16, identified a focus area for psychotropic drug use. The interventions included medication as ordered, observe for medication effectiveness, abnormal involuntary movement scale (AIMS) per facility policy. However, the care plan lacked identification of target behaviors and nonpharmacological interventions to be attempted prior to the administration of the PRN lorazepam.	2 560		

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2 560	Continued From page 19 R139's medication administration record (MAR) indicated R139 had received lorazepam on 12/8/15, 12/18/15, 1/1/16, 1/4/16, 1/9/16, 1/13/16, 1/21/16, and 1/30/16. however, the record lacked documentation related to what non-pharmacological interventions had been attempted prior to the use of the medication. On 2/3/16, at 8:15 a.m. RN-E stated R139 had not utilized her PRN Ativan in February to date, but did use it in January. RN-E stated she would use the PRN medication if R139 had increased anxiety and would document on the MAR it was given for anxiety. RN-E further stated she did not document any where what she did before giving the medication. RN-E stated she did not know what R139's target behaviors were or non pharmacological interventions to be attempted prior to the use of the Ativan. RN-E stated it was not identified on the MAR. On 2/3/16, at 1:50 p.m. RN-D stated R139 received PRN lorazepam, but did not know what R139's target behaviors or non-pharmacological interventions were. RN-D verified there was no information on R139's MAR, or care plan identifying target behaviors and non pharmalogical interventions to be attempted prior to the use of the PRN lorazepam. On 2/3/16, at 2:03 p.m. the licensed social worker (LSW) stated target behaviors and non-pharmacological interventions should have been listed on R139's MAR. LSW stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which should	2 560		

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2 560	Continued From page 20	2 560		

have been on the MAR for monitoring and implementation of interventions prior to PRN medication use. The LSW verified R139's medical record, MAR and care plan lacked target behaviors and non-pharmacological interventions and stated they should have been there.

On 2/3/16, at 2:33 p.m. the DON verified R139's target behaviors and nonpharmacological interventions should have been identified on R139's care plan.

R136 was prescribed risperidone (Risperdal) (antipsychotic) as needed, the facility failed to ensure a comprehensive care plan was developed identifying target behaviors and non pharmalogical interventions to be attempted prior to the administration of the as needed risperidone medication.

R136's Integrated Problem List/Diagnostic Records sheet undated, indicated R136 had diagnoses which included, dementia with paranoid thoughts and diabetes.

R136's physician orders dated 1/31/16, and 12/3/15, indicated R136 was to receive risperidone 0.25 mg twice a day and 0.5 mg 1/2 tablet twice daily PRN.

R136's care plan identified a focus area for psychotropic drug use revised 1/18/16, which indicated R136 had Alzheimer's dementia with behaviors and paranoia, received scheduled antipsychotic and antidepressant medications

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2 560	Continued From page 21 with a failed dose reduction of both meds 3/15. The interventions included medication as ordered, observe for medication effectiveness, abnormal involuntary movement scale (AIMS) per facility policy. In addition, the care plan indicated a Mood / Behavior focus area revised on 8/20/15, which indicated R136 wandered, became paranoid and believed others had stolen her belongings. The plan indicated R136 was easily directed. The plan directed staff to listen to R136's concerns, acknowledge feelings, provide reassurance, redirect when in other resident rooms, check for thirst/toileting/ pain/hunger and encourage activities. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN risperidone. R136's MAR indicated R136 was administered risperidone 0.5 mg 1/2 tablet bid three times in January on 1/5/16, 1/8/16, and 1/9/16, for increased anxiety. No use in February to date. R136's medical record lacked Target Behavior Flow Sheets. On 2/4/16, at 10:56 a.m. RN-C stated R136's MAR did not identify any target behaviors nor non-pharmacological interventions to be attempted prior to the use of the PRN medication. RN-C stated she had seen those for others which was usually identified on the MAR. RN-C verified R136 did not have any listed. RN-C stated she could list the interventions that work for R136 but they were just not identified.	2 560		

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2 560	Continued From page 22 On 2/4/16, at 1:59 p.m. RN-B stated target behaviors and non-pharmacological interventions should have been identified for R136 and staff were expected to attempt and document as well. RN-B verified there were no target behaviors or non-pharmacological interventions identified in R136's record, or on the care plan. On 2/3/16, at 2:03 p.m. the LSW-A stated target behaviors and non-pharmacological interventions should have been listed on R136's MAR right below the medication. LSW-A stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which should have been on the MAR for monitoring and implementation of interventions prior to PRN medication use. On 2/3/16, at 2:33 p.m. the DON verified target behaviors and non-pharmacological interventions should have been identified and attempted prior to administering R136's PRN risperidone and R136's care plan should have reflected that. R153 was administered PRN Seroquel and the facility failed to ensure a comprehensive care plan was developed identifying target behaviors and non pharmalogical interventions to be attempted prior to the administration of the as needed antipsychotic medication. R153's Physician Order sheet dated 2/4/16, indicated R153 had diagnoses which included Parkinson's disease, chronic obstructive	2 560		

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2 560	Continued From page 23 pulmonary disease (a lung condition), and Lewy Body dementia (an aggressive dementia which can cause hallucinations, rigid muscles, slowed movement and tremors). R153's physician orders dated 2/4/16, included the following: - Seroquel 50 mg (milligrams) twice a day which was started 5/22/15. - Seroquel 100 mg at bedtime which was started 7/8/15. - Seroquel 50 mg PRN up to three times a day which was started 9/15/14. - Gabapentin (anticonvulsant medication) 100 mg three times a day which was started 10/14/14. - Trazodone (antidepressant) 75 mg daily started on 11/21/14. R153's care plan dated 11/25/15, identified a focus area for psychotropic drug use related to agitation with severe encephalopathy, severe Parkinsonism and Lewy body dementia which was initiated on 9/25/14. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, abnormal involuntary movement scale (AIMS) per facility policy and review for potential side effects. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN Seroquel. The care plan also identified a focus area for mood and behavior which indicated R153 displayed hitting and swearing with cares. The interventions included offer to walk the resident, leave the resident alone and return, try a different caregiver, try a different approach and offer apple juice.	2 560		

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2 560	Continued From page 24 R153's Target Behavior forms for 12/1/15 - 2/4/16, identified R153's target behavior as hitting and swearing at staff with cares. Approaches identified included secure others and resident safety and leave resident alone, wait ten minutes and return, try a different caregiver, speak calmly and slowly. R153's nursing progress notes and behavior sheets were reviewed and revealed R153 received Seroquel 50 mg PRN 14 times from 12/1/15 - 2/4/16. The medical record lacked the following information related the use of the PRN Seroquel: -Documentation of target behaviors (hitting and swearing at staff with cares) six out of the 14 times 12/10/15, and 12/14/15 (R153 was given 3 doses on this day), 12/17/15, 12/20/15, 1/14/16) all lacked target behaviors resulting in the administration of the PRN medication. -Documentation of non-pharmacological interventions trialed prior to the administration of the PRN Seroquel eight out of 14 times on 12/7/15, 12/10/15, 12/14/15 (given three doses only documentation for one dose), 12/17/15, 12/19/15, 12/20/15, and 1/14/16. On 2/4/16, at 2:43 p.m. R153 was observed seated in his tilt back wheelchair stationed on the outskirts of the nursing station. R153 was alert, calm and watched as other staff and residents passed by. On 2/5/16, at 1:16 p.m. LPN-D verified R153 had	2 560		

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2 560	Continued From page 25 PRN Seroquel ordered. LPN-D stated R153 usually received the PRN Seroquel four to five times a month when R153 exhibited behaviors such as hitting or punching staff. When asked about non-pharmacological interventions, LPN-D stated they could offer R153 apple juice or give him a ride in his wheelchair. LPN-D stated overall, the staff could do a better job of documenting the target behaviors exhibited and non-pharmacological interventions attempted. On 2/5/16, at 1:41 p.m. RN-B confirmed the expectation was for staff to document the specific behavior exhibited by R153 and the non-pharmacological interventions trialed prior to the administration of the PRN Seroquel. In addition, target behaviors and non-pharmacological interventions should specifically be identified on the care plan. RN-B confirmed R153's care plan lacked these specifics. On 2/5/16, at 2:02 p.m. consulting pharmacist (CP)-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R153's PRN Seroque The facility Care Plans policy dated 4/1/2008, indicated the facility develops a comprehensive care plan for each resident including measurable objective and timetables to meet the medical, nursing, mental and psychosocial needs, as identified in the comprehensive assessments. SUGGESTED METHOD OF CORRECTION: The	2 560		

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2 560	Continued From page 26 director of nursing or designee could review and / or revise the policies and procedures related to the development of a care plan. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF 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 in accordance with the resident's written care plan for 1 of 3 residents (R183) who required every one hour repositioning assistance and was observed to not receive the assistance. Findings include: R183 was not provided every one hour repositioning assistance as directed by the care plan.	2 565	Corrected	3/29/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 27 R183's care plan dated 12/17/15, indicated R183 was at high risk for pressure ulcer/skin issues related to impaired mobility, dementia, weakness and incontinence. In addition, the care plan indicated R183 had a stage 2 (outer layer of skin and part of the underlying layer of skin is damaged or lost. The wound may be shallow and pinkish or red, a fluid-filled blister or a ruptured blister) to his left heel upon admission to the facility. On 1/18/16, an open pressure sore on R183's left heel and an intact blister on right heel were added to the care plan. An open sore on coccyx/sacral (tailbone) was also added to the care plan with no date of this addition. Interventions directed staff to administer treatments as ordered, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing daily, pressure relieving wheelchair cushion and mattress, elevate heels off bed with pillows at all times and heel protectors on while in bed. On 1/18/16, the intervention to turn and reposition every one hour when in bed was added. R183's nursing assistant care guide directed staff to assist R183 with bed mobility and all activities of daily living, apply heel protectors and keep heels elevated off the bed and reposition every 1 hour. On 2/3/16, from 7:05 a.m. until 9:08 a.m. continuous observations revealed the following: -At 7:05 a.m. R183 was observed laying in bed, positioned on his right side. -At 7:33 a.m. nursing assistant (NA)-I entered R183's room with a sit to stand lift and gathered towels and morning care supplies. R183 stated he was thirsty and NA-I obtained a fresh cold	2 565		

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2 565	Continued From page 28 glass of water and after raising the head of the bed up slightly handed the glass to R183 which he drank. R183 remained on his right side. NA-I offered to wash R183 up and get him up out of bed. R183 refused at this time. NA-I tidied up R183's room, took out the garbage and dirty laundry, placed call light within R183's reach and prior to exiting R183's room, NA-I washed her hands. -At 7:50 a.m. NA-I exited R183's room. R183 remained positioned on his right side. During this encounter NA-I had not offered R183 to have his brief checked, toileted or repositioned. -At 7:55 a.m. licensed practical nurse (LPN)-D entered room and assisted R183's roommate and exited the room. -At 8:25 a.m. the director of nursing (DON) poked her head in the doorway and stated she was just checking on the residents. -At 9:08 a.m. (two hours and three minutes without being repositioned) NA-I and LPN-D entered R183's room, moved R183 up in bed, rolled him from side to side and checked and changed his incontinent brief, assured R183's blue foam boots remained in position on both heels and placed a pillow under R183's feet then exited the room. On 2/3/16, at 9:19 a.m. NA-I confirmed R183's care guide directed staff to reposition him every one hour. NA-I verified R183 went longer than one hour before being repositioned. On 2/3/16, at 9:54 a.m. RN-B confirmed R183 should have been repositioned every one hour and both R183's care plan and care guide directed staff to reposition R183 every one hour. RN-B stated once R183 acquired the sacral pressure ulcer the care plan had been changed	2 565		

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2 565	Continued From page 29 from an every two hour to an every one hour turning/repositioning schedule. RN-B stated it was her expectation R183 would be repositioned every one hour and that waiting over two hours was too long. RN-B confirmed R183 was at risk for the development of pressure ulcers. On 2/4/16, at 8:41 a.m. the DON confirmed it was her expectation for staff to follow R183's care plan with regards to pressure ulcer care which included the every one hour turning and repositioning schedule. Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated the facility had in place a system for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. In addition, appropriate turning and repositioning schedules would be put in place and the care plan updated. Residents who have a loss of skin integrity would receive the appropriate treatments/services which included a repositioning or off-loading plan. Also all interventions and treatments should be evaluated for efficacy and modified/changes as needed. Care plans should be revised if there was a lack of progress towards healing or when a resident acquired a new ulcer. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to the implementation of the care plan to ensure care is provided as directed by the care plan. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan.	2 565		

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2 565	Continued From page 30 TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 565		
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 interview and document review, the facility failed to perform neurological assessments following a fall as directed by facility policy for 1 of 1 resident (R180) who had fallen and sustained head and neck injuries and required neurological checks. Findings include: On 2/2/16, at 11:35 a.m. registered nurse (RN)-A stated R180 had sustained a fall the morning of 2/2/16, resulting in a large goose egg on her forehead.	2 830	Corrected	3/29/16

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2 830	Continued From page 31 The incident report dated 2/2/16, at 8:00 a.m. indicated a staff member had witnessed R180 ambulating independently in the hallway. R180's brief began to fall down, R180 attempted to bend over, pull up the brief and fell forward onto her face. The report indicated R180 sustained a bruised and swollen forehead. A cold compress was applied. The Falls Risk Post Falls Assessment dated 2/2/16, indicated R180 had a history of dementia and was occasionally able to communicate her needs. She did not have any changes in her pain status, nor had R180 expressed symptoms of depression or been recently hospitalized. The interventions to be implemented as a result of the assessment included R180 was to utilize a pullup (underwear style) incontinent product was sent to the emergency room for further evaluation. R180's Nurse's Record and Progress notes revealed the following information: - 2/2/16, at 9:30 a.m. indicated R180 had fallen while ambulating independently in the hallway. R180's incontinent brief slid down, causing R180 to fall hitting her head. R180 was evaluated / examined by the nurse practitioner. - 2/2/16, at 12:30 p.m. indicated R180's bruise spread to the full front of her forehead and down past eyes and right eye becoming almost completely shut. The nurse practitioner was contacted and directed R180 to be evaluated in the emergency room. - On 2/2/16, at 2:40 p.m. R180 was transferred to	2 830		

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2 830	Continued From page 32 the emergency room via ambulance. - On 2/2/16, at 7:00 p.m. the emergency room nurse had called the facility and informed them R180 had sustained nondisplaced fractures in cervical vertebra of C1 and C2. R180 was to utilize a Miami J Collar (neck brace) on at all times and was to follow up with neurology appointment in one week. - On 2/2/16, at 8:10 p.m. R180 returned from the emergency room wearing a Miami J collar which was recommended to be on at all times. "resident keeps taking off her collar and is resistant to keeping it on." R180's Neurological Assessment Flowsheet initiated 2/2/16, at 8:15 a.m. revealed neurological assessments were completed every hour through 11:15 a.m. An assessment was documented as being completed at 3:15 p.m. however, at this time, R180 was at the emergency room. The remaining every four hour checks were crossed out with "hospital" indicated. The flowsheet also included a staff directive to obtain complete vital signs and neuro assessments to be performed every hour for four hours then every 4 hours for 24 hours post incident with head injury. R180's medical record lacked further neuro or vital sign assessments between the hours of 3:15 p.m. on 2/2/16 through 6:00 a.m. on 2/3/16. R180's medical record indicated R180 returned from the hospital emergency room at 8:10 p.m. however, the record lacked notation of R180's cognitive status, behaviors, pain or condition upon returning from the hospital with a newly diagnosed neck fracture and head injury.	2 830		

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2 830	Continued From page 33 A second Neurological Assessment Flowsheet was initiated on 2/3/16, at 6:00 a.m. and revealed every two hour vital sign / neuro assessments were obtained. On 2/3/16, at 11:48 a.m. licensed practical nurse (LPN)-A verified R180 had sustained a fall with injuries and she would be completing neuro checks on R180 and would offer R180 pain medication. She stated R180 had been resistive with cares and the staff were to follow R180's desires. On 2/3/16, at 12:40 p.m. RN-A confirmed R180's neuro assessments or vital signs had not been competed between the hours of 7:15 p.m. on 2/2/16 and 6:00 a.m. 2/3/16, following the fall with injuries. RN-A stated it was facility protocol to complete neurological examinations every hour for the first five hours and every four hours for 24 hours following a fall. RN-A verified R180's medical record lacked documentation related to R180's condition between 8:10 p.m. to the present time. She stated she had re-started neurological examinations at 6:00 a.m. this morning when she had identified the neurological examinations had not been completed. On 2/3/16, at 1:53 p.m. the director of nursing (DON) reviewed R180's record and confirmed the record lacked documentation of the completion of neuro checks / vital signs or a nurses notes regarding R180's condition upon her return from the emergency room. The DON verified the last notation in R180's medical record from 2/2/16,	2 830		

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2 830	Continued From page 34 indicated R180 had returned from the emergency room with a cervical neck non displaced fracture as well as facial bruising. The Accidents/Fall policy dated 4/1/08, and updated on 2/2014, directed staff to provide emergency care and complete neurological observations following any incident of a resident suspected of hitting their head. The staff were to investigate the incident to determine the cause of the episode, complete post fall assessments, update the resident care plan and to complete continued follow up charting for 72 hours to assess for possible injuries as well as to futher evaluate the interventions put into place. The facility's Neurological Observations policy dated 4/1/08, directed staff to perform neurological examinations every 15 minutes for one hour, followed by every 30 minutes for one hour, followed by every hour for two hours then once a shift for 72 hours or as directed by the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to neurological assessments following a fall with head injury. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 830		

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a timely comprehensive assessment following the identification of a stage two pressure ulcer in order to prevent and / or promote the healing of pressure ulcers and failed to provide every one hour turning and repositioning as directed by the care plan for 1 of 3 residents (R183) admitted with intact skin who developed three stage two pressure related ulcers following admission to the facility. This resulted in actual harm to R183. Findings include: R183's Nurses Admission Notes form indicated R183 was admitted 12/17/15, was independent with bed mobility and was forgetful with repetitive	2 900	Corrected	3/29/16

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2 900	Continued From page 36 speech. The note directed the reader to refer to R183's skin assessment for status of skin condition. R183's Skin: Admission Skin Examination / Evaluation form dated 12/17/15, indicated R183 had a skin tag on left outer knee, skin was cool, warm and had bilateral pitting ankle/feet edema. The form also indicated R183 had "soft heels." No mention of a pressure ulcer noted. R183's Nurse's Record and Progress Notes (NRPN) dated 12/17/15, titled "Admit" indicated R183 was non-ambulatory and required the use of a mechanical lift for transfers. There was no mention of a pressure related ulcer. R183's NRPN dated 12/17/15, at 10:30 p.m. indicated R183 was alert but very forgetful with repetitive speech and had bilateral pitting edema in the feet and ankles. Elevate feet in bed. No mention of a pressure related ulcer noted. R183's Short Term Care Plan dated 12/17/15, indicated R183 utilized a pressure reducing mattress in bed and pad in wheelchair. The plan directed staff to provide repositioning every two hours in bed and wheelchair, elevate heels off bed with pillows and heel protectors to be worn when in bed. R183' Nursing Home physician visit note dated 12/21/15, indicated R183 was diagnosed with dementia, anemia, arthritis of hip and osteoarthritis / degenerative joint disease. The note indicated under the SKIN section, R183 had actinic (precancerous patch of thick, scaly or crusty skin) changes on the hands and face. No mention of a pressure related ulcer noted.	2 900		

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2 900	Continued From page 37 R183's NRPN dated 12/21/15, indicated R183 was alert and confused, transferred with mechanical lift and one staff assistance required with bed mobility. R183's Braden Scale (tool used to predict risk for pressure ulcers) dated 12/23/15, revealed a score of 17. The form indicated a resident with a score of 16 or less was to be considered at risk for developing pressure ulcers. R183's NRPN dated 12/24/15, indicated nursing assistant (NA) found a blister on R183's left outer heel during morning shower. The note indicated the blister measured 2.8 centimeters (cm) X 2.7 cm and was fluid filled. R183's NRPN dated 12/24/15, at 12:30 p.m. indicated soft boots were ordered for R183 to wear while in bed to prevent further blisters. R183's NRPN dated 12/24/15, at 10:00 p.m. indicated left outer heel blister dry and intact, blue pillow boots in place at HS (hours of sleep). R183's admission Minimum Data Set (MDS) dated 12/24/15, with an assessment reference end date of 12/24/15, indicated R183 had severe cognitive impairment and required extensive assistance of two staff with bed mobility and toileting, extensive assist of one staff for transferring and personal hygiene. In addition, The MDS indicated R183 had a stage two (partial thickness, loss of skin with a red-pink wound, without dead tissue) pressure ulcer, was at risk for pressure ulcers, utilized a pressure relieving device in the bed and chair, was not on a turning and repositioning schedule and received pressure ulcer care. The MDS did not indicate where the stage two pressure ulcer was located.	2 900		

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2 900	Continued From page 38 R183's Pressure Ulcer Care Area Assessment (CAA) dated 12/28/15, indicated R183 was at risk for the development of a pressure ulcers / skin issue due to dementia and was noted to have a fluid filled blister on 12/24/15. The CAA also indicated R183 was dependent on staff to meet his needs, was frequently incontinent of bladder, always incontinent of bowel, needed reminders to off load (relieving the pressure to an area) and reposition, was to wear blue boots while in bed and utilized a pressure relieving cushion in the wheelchair and bed. In addition, wound care would assess R183's wound weekly. R183's Nutrition Status CAA dated 12/29/15, indicated R183 was found to have a left outer heel blister and nursing to apply soft pillow boots to prevent further blisters. R183's Tissue Tolerance (Bed) algorithm assessment form (used to determine the skin's ability to withstand pressure without position change) dated 12/28/15, (completed four days following the identification of a stage two ulcer) indicated this assessment tool was to be completed upon admission, annually and with any significant change in status, upon emergence of pressure ulcers and with changes in pressure surfaces. The form indicated R183 was not independent in mobility/positioning and directed staff to follow the identified algorithm. The form directed staff to inspect R183's skin after R183 had been in the same position for two hours. The form indicated R183 had skin redness which did not blanch and directed the assessor to re-exam the skin after one hour. The next checked area indicated R183's skin was no longer reddened and to consider care plan directive to reposition R183 every two hours. The form also indicated determination of a positioning schedule should be	2 900		

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2 900	Continued From page 39	2 900		

conducted in conjunction with a Comprehensive Skin Risk Collection Tool, the Braden Assessment, and resident's preferences and were to be included in the analysis.

R183's Comprehensive Skin Risk Data Collection form dated 12/28/15, (completed four days after the identification of a stage two ulcer) indicated R183 preferred to lay supine (on back) in bed and was to be provided offloading every two hours in bed and wheelchair, heels elevated, heel protectors and incontinence cares. In addition, this Data Collection form indicated R183 had a Rest Q pressure relieving mattress on his bed. The note further indicated R183 had "soft heels," with no actual open areas identified and a trace of lower extremity edema. A hand written analysis indicated R183 had cognitive and mobility impairment, was non-ambulatory, utilized mechanical lift for transfers, was dependent on staff for cares, offloading and repositioning, and peri cares were to be provided after each incontinent episode. There was no mention of a pressure related ulcer noted.

R183's Short Term Preventative Skin Care Plan dated 12/28/15, indicated R183 required assistance with repositioning in the bed and chair, was unable to walk or transfer without assistance and was incontinent of bowel and bladder. The plan directed staff to change R183's position every two hours, wear heel protectors, elevate heel off of bed and to utilize a pressure relief mattress and wheelchair pad.

R183's 14 day MDS dated 12/31/15, indicated R183 required extensive assist of two staff for bed mobility, extensive assist of one staff for transfers, did not walk in room and walked 1-2 times in the corridor, was at risk for pressure

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2 900	Continued From page 40 ulcers, had one stage two pressure ulcer which was present on admission (refer to admission skin assessment which indicated R183 skin was intact with soft heels), utilized a pressure reducing device in the bed and chair, was not on a turning and repositioning schedule and received pressure ulcer care. R183's current comprehensive care plan for Nutritional/Hydration/Dental initiated on 12/18/15, revealed a hand written entry dated 12/24/15, which indicated R183 had an intact left heel blister and indicated R183 was to utilize blue boots on both feet at HS. R183's current comprehensive care plan indicated a high risk for pressure ulcers / skin issues was initiated on 1/15/16, related to impaired mobility, dementia, weakness and incontinence. The plan indicated R183 was admitted to the facility with a stage 2 pressure ulcer on left heel. A hand written entry dated 1/18/16, indicated R183 had an open pressure sore on left heel and intact blister on right heel. In addition, an undated, hand written entry indicated R183 also had an open sore on the coccyx /sacral area (tail bone). The plan directed staff to administer meds / treatments as ordered, assess/record/monitor wound healing during rounds and to assess and document wound healing. The plan further directed staff to reposition / boost up in bed with two assist and use of draw sheet, to turn and reposition at least every two hours or more often as needed, follow facility policies / protocols for the prevention / treatment of skin breakdown, monitor dressing daily, pressure relieving wheelchair cushion and mattress, elevate heels off bed with pillows at all times and heel protectors on while in bed. A hand written updated entry dated 1/18/16,	2 900		

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2 900	Continued From page 41 directed staff to turn and reposition R183 every one hour when in bed and keep heels elevated. R183's 30 day MDS dated 1/14/16, indicated R183 required extensive assist of two staff for bed mobility, extensive assist of one staff for transfers, and did not walk. The MDS also indicated R183 was at risk for pressure ulcers, had one stage two pressure ulcer which was present on admission, R183 utilized a pressure relieving device in the bed and chair, was not on a turning and repositioning schedule and received pressure ulcer care. R183's wound assessment flow sheets revealed the following on each pressure ulcer: Sacral pressure ulcer was acquired at the facility with an onset date of 1/20/16. No stage of the ulcer was noted on this form. There were no nurse's notes related to the identification of this wound. The measurements of the sacral pressure ulcer were documented as: -1/21/16, 1.3 cm x 0.7 cm x 0 cm -1/25/16, 0.5 cm x 0.5 cm x 0 cm -1/27/16, 0.5 cm x 0.5 cm x 0 cm -2/3/16, 1.5 cm (an increase of 1 cm from last measurement and an increase of 0.2 cm from when acquired) x 1.2 cm (an increase of 0.7 cm since last measurement and an increase of 0.5 cm from when acquired) -A hand written progress note on the Wound Assessment Flow Sheet dated 1/21/16, indicated new orders written and new mattress ordered. An additional note dated 1/25/16, indicated wound looks same, measurements same. -A hand written progress note dated 1/27/16, indicated NP observed wound and changed treatment.	2 900		

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2 900	Continued From page 42 Right heel pressure ulcer was unstageable (wound with full thickness tissue loss in which the base of the ulcer is completely covered with slough (dead tissue or eschar (dry dark scab) in the wound bed) and had been acquired at the facility (unknown date of onset). The measurements of the right heel pressure ulcer were documented as: -1/19/16, 2.5 cm x 2.5 cm x 0 cm -1/27/16, 2.5 cm x 2.5 cm x 0 cm -2/3/16, 2.7 cm (.2 cm larger) x 2.8 (0.3 cm larger) x 0 cm Left heel pressure ulcer was a stage 2 (partial thickness, loss of skin with a red-pink wound, without dead tissue). The admission notes indicated R183 had "soft heels" upon admission to the facility. The onset date of the blister was 12/24/15. The measurements of the left heel pressure ulcer were documented as: -12/31/15, 3.0 cm x 3.0 cm -1/7/16, 3.0 cm x 3.0 cm -1/15/16, 4.0 cm x 4.0 cm -1/19/15, 4 .0 cm x 3.5 cm x 0 cm -1/24/16, 3.0 cm x 2.0 cm x 0 cm -1/27/16, 2 cm x 2 cm x 0 cm -2/3/16, 2.1 cm x 3 cm x 0 cm -A hand written progress note on the Wound Assessment Flow Sheet indicated on 12/31/15, the fluid was drained from the blister and skin flap debrided. New dressing order obtained, wound bed beefy red, granulation 100%, surrounding skin intact with no signs of infection. A special pressure reducing mattress on bed and staff to elevate heels and ensure heel boots are in place. -A hand written progress note dated 1/15/16, indicated wound measurements are slightly	2 900		

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2 900	Continued From page 43 bigger, wound edges macerated and a heavy amount of serosanguinous (serum and blood) drainage. No signs of infection. -A hand written progress note dated 1/19/16, indicated wound looking better, appears to be getting smaller. -A hand written progress noted dated 1/21/16, indicated wound getting smaller. -A hand written note dated 1/27/16, indicated NP debrided wound and changed treatment. A Tissue Tolerance (Bed) algorithm form dated 1/22/16, (completed two days after the identification of the sacral ulcer and three days after the first documentation of the right heel pressure ulcer) indicated this assessment tool was to be completed upon admission, annually and with any significant change in status, upon emergence of pressure ulcers and with changes in pressure surfaces. The form indicated R183 was not independent in mobility/positioning and directed the assessor to inspect R183's skin after R183 had remained in the same position for two hours. The form indicated R183 had no change in skin discoloration after two hours without repositioning and directed the assessor to reposition R183 and re-exam the skin after R183 had remained in the same position for three hours. The rest of the form was blank. There were no follow up notations indicated. The form also indicated determination of a positioning schedule should be done in conjunction with a Comprehensive Skin Risk Collection Tool, the Braden Assessment, and resident ' s preferences were to be included in the analysis. R183's nursing assistant care guide dated February 3rd 2016, directed staff to assist R183 with bed mobility and to reposition R183 every one hour and to ensure R183 had a pressure	2 900		

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2 900	Continued From page 44 relieving mattress, heel protectors with heels elevated off the bed with pillows and pressure reducing cushion in the wheelchair. On 2/3/16, during continuous observations from 7:05 a.m. until 9:08 a.m. the following was observed: -At 7:05 a.m. R183 was observed lying in bed positioned on his right side. -At 7:33 a.m. nursing assistant (NA)-I entered R183's room with a sit to stand lift and gathered towels and morning care supplies. R183 stated he was thirsty and NA-I obtained a fresh cold glass of water and after raising the head of the bed up slightly handed the glass to R183 which he drank. R183 remained on his right side. NA-I offered to wash R183 up and get him up out of bed. R183 refused at this time. NA-I tidied up R183's room, took out the garbage and dirty laundry, placed call light within R183's reach, washed her hands and at 7:50 a.m. exited the room. R183 remained positioned on his right side. During this encounter NA-I had not offered R183 to have his brief checked, toileted or repositioned. Nor where the risks and benefits of not being repositioned explained to R183. -At 7:55 a.m. licensed practical nurse (LPN)-D entered room and assisted R183's roommate -At 8:25 a.m. the director of nursing (DON) poked her head in the doorway and stated she was just checking on the residents. -At 9:08 a.m. (two hours and 3 minutes without being repositioned) NA-I and LPN-D entered R183's room, moved R183 up in bed, rolled him from side to side and checked his brief (which was dry), applied a new brief, assured R183's blue foam boots remained in position on both heels and placed a pillow under R183's feet and then exited the room.	2 900		

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2 900	Continued From page 45 On 2/3/16, at 10:56 a.m. LPN-D, nurse practitioner (NP)-A and registered nurse (RN)-B were observed to provide wound care and obtain measurements of R183's three active pressure ulcers. They confirmed the current measurements of R183's three existing pressure ulcers were: -Right heel pressure ulcer - 2.7 centimeters (cm) in length by 2.8 cm in width by 0 cm depth -Left heel pressure ulcer - 2.1 cm by 3.0 cm x 0 cm -Sacral pressure ulcer - 1.5 cm x 1.2 cm x 0 cm A Tissue Tolerance (Bed) algorithm assessment form completed during the survey on 2/3/16, indicated this assessment tool was to be completed upon admission, annually and with any significant change in status, upon emergence of pressure ulcers and with changes in pressure surfaces. The form directed the assessor to inspect R183's skin after R183 had remained in the same position for two hours. The form indicated R183 had skin redness present but was blanchable and directed the assessor to reposition R183 and re-exam the skin after R183 had been in the same position for three hours. The documentation missed a step in the algorithm procedure with the next identified area indicating R183's skin had redness and to consider to care plan directive to reposition R183 every three hours. The form also indicated determination of a positioning schedule should be done in conjunction with a Comprehensive Skin Risk Collection Tool, the Braden Assessment, and resident ' s preferences were to be included in the analysis. On 2/3/16, at 9:19 a.m. NA-I confirmed according	2 900		

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2 900	Continued From page 46 to R183's care guide he should be repositioned every one hour and verified R183 was not repositioned hourly and had went longer than one hour before being repositioned. On 2/3/16, at 9:54 a.m. RN-B confirmed R183 was at risk for the development of pressure ulcers and verified R183 was to be repositioned every one hour also and verified both R183's care plan and care guide directed staff to reposition R183 every one hour. RN-B verified R183 had three current pressure ulcers. RN-B stated once R183 acquired the sacral pressure ulcer, the care plan had been changed from an every two hour to an every one hour turning / repositioning schedule. RN-B stated it was "absolutely" her expectation that R183 be repositioned every one hour and that waiting over two hours to reposition, was too long. RN-B confirmed R183's skin assessment had not been re-evaluated after the acquired pressure ulcers had been identified and normally RN-B would expect for this to be done. On 2/3/16, at 6:31 p.m. RN-B confirmed R183's sacral wound measurement from today (2/3/16) indicated R183's wound had worsened and was even larger in size then what it was when it was first acquired. At the same time, the DON also confirmed R183 was to be repositioned every hour which was implemented when R183's sacral wound was identified. The DON also stated waiting two hours to be repositioned was too long for R183. On 2/4/16, at 8:41 a.m. the DON confirmed it was her expectation for staff to follow R183's care plan with regards to pressure ulcer care which included the every one hour turning and repositioning schedule. On 2/5/16, at 11:18 a.m. NP-A verified R183's	2 900		

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2 900	Continued From page 47 sacral wound was a stage 2 pressure ulcer. Pressure Ulcers/Skin Integrity/Wound Management policy dated 9/13/11, indicated the facility had in place a system for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. The policy indicated a "head to toe" skin assessment would be completed on admission or within 24 hours of admission and a Tissue Tolerance test (both lying and sitting) and a Braden skin assessment would also be conducted within 24 hours of admission. All residents' were preventatively placed on a pressure reduction mattress and cushion in the wheelchair based on the skin assessment and an appropriate turning and repositioning schedule would be put in place and the care plan updated. Residents who have a loss of skin integrity would receive the appropriate treatments/services which included a repositioning or off-loading plan. Also all interventions and treatments should be evaluated for efficacy and modified/changes as needed. Care plans should be revised if there was a lack of progress towards healing or when a resident acquired a new ulcer. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to pressure ulcer prevention and care. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 900		

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2 915	Continued From page 48	2 915		
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 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 re-evaluate a resident's ambulation ability after a decline in ambulation was identified for 1 of 3 residents (R156) in the sample. The resident's decline in ability to ambulate resulted in actual harm. Findings include: R156's admission MDS dated 9/10/15, indicated R156 was diagnosed with cancer, a stroke and tremors. The MDS also indicated R156 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, transfer and ambulation in his room and the	2 915	Corrected	3/29/16

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2 915	Continued From page 49 corridor. The MDS also indicated R156 was unsteady with transitions and ambulation and required staff assistance to stabilize. R156 utilized a wheelchair for mobility, had no functional limitation in range of motion impairment and R156 and staff believed R156 was capable of increased independence in at least some of the activities of daily living. R156's quarterly MDS dated 12/4/15, indicated R156 required extensive assistance with two staff for bed mobility, transfers, R156 did not walk in his room or corridor, utilized a walker and wheelchair for mobility and had no functional limitations in range of motion impairment. R156's discharge summary from a previous facility dated 9/2/15, indicated R156 was able to transfer and ambulate short distances. He had the ability to use a wheelchair and did not attempt to self -transfer. R156's Nurse's Record and Progress Notes (NRPN) dated 9/15/15, indicated R156 was independently ambulating, staff gave R156 walker and followed R156 with the wheelchair. R156 ambulated to the dining room. R156's care plan dated 9/23/15, directed staff to ambulate R156 with extensive assistance of two staff, as needed. The plan also indicated R156 displayed physical aggression and exiting seeking behaviors and was not easily directed. Staff were directed to redirect R156 as able, encourage activities of choice and 1:1 conversation. The plan indicated R156 was to remain on the secured dementia unit. R156's Nursing Rehab program / Functional Maintenance program form, established by	2 915		

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2 915	Continued From page 50	2 915		

physical therapy to be implemented following the discontinuation of physical therapy, dated 10/5/15, and to begin on 10/6/15, directed the nursing assistants to please ambulate R156 one time per day, five days a week using a front wheeled walker with a wheelchair to follow 100 plus feet with minimal assist of one staff for steering the walker as resident pushes walker to the right. R156's goal of the program was to maintain ability to ambulate at least 100 feet daily with staff. The form directed staff to report resident status to the physical therapist.

R156's Physical Therapy Discharge Summary dated 10/8/15, indicated R156 had received therapy for increasing functional ability, increasing independence and increase lower extremity strength by the use of therapeutic exercises from 9/4/15-10/8/15. The discharge summary indicated R156 required minimal staff assistance to ambulate on level surfaces, had decreased gait ability and generalized weakness.

R156's NRPN dated 11/3/15, indicated R156's walking program was reduced due to lack of resident participation. R156 was to be ambulated 25 feet three times a week.

R156's NRPN dated 11/11/15, indicated R156 had refused ambulation program regularly. R156's ambulation program was discontinued, however, staff directed to ambulate R156 if he became anxious or attempted to stand several times. Staff to continue to attempt to walk R156.

R156's NRPN dated 12/10/15, indicated walking program initiated but discontinued due to lack of resident participation. Staff to walk R156 with extensive assist of two as R156 allowed. R156's NRPN's revealed aggressive behaviors during the

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2 915	Continued From page 51 provision of cares but did not address / specify aggressive resistive behaviors related to ambulation services. R156's ambulation program documentation revealed the following information: -October 2015, Restorative Nursing documentation form directed staff to ambulate R156 with two staff 100 feet or more five times per week. The dates of 10/1/15, through 10/16/15, were crossed out. From 10/17/15, through 10/31/15, R156 ambulated six times with a distance ranging from 10 to 475 feet. R156 had refused to ambulate three times. The rest of the form was blank. -The October 2015, Documentation Survey Report revealed staff signatures for walking in the corridor on either the day, evening or night shift but did not indicate whether R156 ambulated or not. The same form also revealed a section related to ambulation in the room which also indicated staff signatures but not if R156 had ambulated or not. - November 2015, R156 was to ambulate with two staff 25 feet as tolerated. The documentation indicated R156 was offered to ambulate on five different occasions in which R156 refused each time. The rest of the form was blank. The record did not indicate why R156 refused to participate or interventions attempted to promote participation. On 11/11/15, RN-A reviewed the ambulation program and indicated R156 refused to participate. She indicated R156 would become combative with staff when ambulation was attempted. Therefore, RN-A discontinued R156's ambulation program and directed staff to ambulate R156 if he was anxious or attempting to	2 915		

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2 915	Continued From page 52 independently stand. There was no documentation related to a status report to physical therapy or re-evaluation by physical therapy. However, R156's November 2015, Follow Up Question Report indicated on 11/1/15, 11/3/15, 11/7/15 (x2), 11/9/15, 11/12/15, 11/13/15, 11/15/15 (x2), 11/16/15, 11/19/15, 11/21/15, and 11/27/15, R156 ambulated with extensive assistance, R156 was involved in the activity and staff provided weight bearing support. On 11/23/15, limited assistance only was provided with R156 highly involved in the activity. - December 2015, R156 was to ambulate with two staff 25 feet, as needed. The documentation indicated R156 ambulated zero feet on 10 different occasions, however the documentation did not indicated if R156 had refused or ambulation was not offered. The rest of the form was blank. There was no written analysis by the RN indicating R156's ambulation was reviewed. -The January 2016, Documentation Summary Report indicated R156 ambulated with extensive assist six days during the month. Distance was not documented. -February 2016, no ambulation program documentation was available for review. On 2/3/16, at 8:00 a.m. R156 was observed in his room, seated in a Rock and Go (reclining / rocking) wheelchair. RN-A was observed to attempt to push R156's wheelchair, however, R156 put his feet on the ground and refused to allow the chair to move. RN-A tipped the chair back enough for R156's feet to come off of the ground and wheeled him into the dining room.	2 915		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

(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
2 915	Continued From page 53 -At 9:30 a.m. nursing assistant (NA)-A was observed to transfer R156 from the wheelchair to the toilet via a standing mechanical lift. R156's knees were shaky but was able to stand and maintain balance while in the lift. On 2/9/16, at 9:45 a.m. NA-T stated R156 did not have the ability to ambulate. She stated R156 was assisted to transfer via a mechanical standing lift. On 2/9/16, at 9:47 a.m. RN-A stated R156 did not have the ability to ambulate well so the ambulation program was discontinued and was changed to an as needed program and if staff noted R156 was anxious or trying to stand alone they were directed to attempt to walk with him. RN-A stated she had not reassessed R156's walking ability. On 2/9/16, at 10:00 a.m. RN-A and nurse consultant (NC)-C were interviewed. RN-A stated R156 was not able to ambulate and verified this was a decline in ability. RN-A stated attempting to ambulate R156 would be dangerous for R156 and the staff. When asked if R156 had been re-evaluated by physical therapy or assessed by nursing following the decline in ability to walk, RN-A stated, "no." NC-C stated when therapy discontinued a resident from services and established a therapy program to be transferred to nursing staff to follow, those discharge instructions were just recommendations for care, not a formal directive at the time of discharge. NC-C stated once a resident was in the care of nursing staff, the RN could decide how to care for the resident related to therapy / exercise program needs. NC-C also stated the physical therapist would not be contacted for further evaluation or screening of the resident ' s ambulation ability	2 915		

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2 915	Continued From page 54 because the RN was responsible for adjusting resident therapy goals. On 2/9/16, at 11:00 a.m. physical therapist (PT)-A stated if a resident was refusing to participate in the walking program and had previously received therapy services, she would expect nursing staff to consult with physical therapy prior to changing / decreasing a resident's program. PT-A stated this coordination was to ensure the therapist's input and knowledge was included in order to assist the resident in maintaining ambulation abilities. PT-A stated if a resident declined and was no longer able to participate in the restorative or functional maintenance program which had been established at the time of discharge from physical therapy, she would expect the staff to contact her for a re-evaluation / screening. PT-A verified physical therapy was not contacted to re-evaluate R156's decline in ambulation. In addition, PT-A stated when a resident was discharged from physical therapy and the therapist identified a walking program, that program was considered a directive as to how to care for the resident related to walking. PT-A stated the program was a directive not a suggested recommendation. On 2/9/16, at 11:20 am. the director of therapy stated the unit managers should have been reviewing each residents' therapy program monthly. The director stated if the managers noticed a resident was not participating in the established program, she would expect the therapy department to be contacted so the therapist could be consulted or they could screen the resident to determine if additional therapy services were needed. The therapy director stated the nursing staff should have consulted with physical therapy prior to discontinuing R156's therapy services.	2 915		

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2 915	Continued From page 55 On 2/9/16, at 11:30 a.m. RN-A confirmed R156's ambulation program was established on 10/5/15, by physical therapy following the discontinuation of therapy services and set up a program for nursing staff to follow which included R156 was to ambulate 100 feet daily. R156's medical record revealed on 11/11/15, RN-A had reviewed R156's walking program which indicated R156's walking program was an as needed basis only. R156's record lacked documentation / re-assessment as to why the program had been decreased from 100 feet to 25 feet. RN-A stated R156 did not have the ability to ambulate 100 feet and he was not safe to attempt to ambulate. A policy related to ambulation was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to ambulation. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 915		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		3/29/16

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21015	Continued From page 56 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the kitchen food storage, preparation and service areas in a clean and sanitary manner. This has the potential to affect all 139 residents who received meals prepared in the kitchen. Findings include: On 2/1/16, at 4:02 p.m. an initial tour of the kitchen was done with the dietary director (DD). On 2/3/16, at 1:27 p.m. a revisit tour was also conducted with the DD and the corporate consultant (CC)-B and the following concerns were observed: -The ceiling tiles had approximately 1 x 3 inch peeling paper strips hanging from the tiles above the large floor mixer. The DD stated the ceiling would be taken care of right away. -The ceiling tiles above the large coffee makers had peeling paper areas which ranged from approximately two to six inches in length. The metal support strips holding the tiles in place were rusted and paint was peeling. The ceiling tiles above the four-three shelf carts which the uncovered and open carafes were kept, had peeling ceiling tiles with two to six inch paper pieces hanging. The DD verified there was a potential for dust and debris to fall from the peeling paper into carafes and coffee service	21015	Corrected	

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21015	Continued From page 57 pots. -There were six loaves of bread observed on the counter. The DD verified toast and sandwiches were prepped on this counter. The ceiling tiles above the counter had numerous peeling paper pieces ranging from 1/5 inches -2/3 inches hanging down from the ceiling over the counter. The DD stated she would get those removed immediately. The DD further stated, the hanging pieces could have dust and debris which could fall on to the counter, bread and toaster which caused a risk of food contamination. -The range hood above the cook stove has three panels which had dust and debris build up. The DD stated this was scheduled to be cleaned shortly as it was usually done every two weeks. On 02/03/2016, at 10:59 a.m. CC-B stated the kitchen was on the facility's remodel list to be completed after the remodeling of resident rooms was completed. The CC-B agreed the kitchen needed to be cleaned and stated staff would be getting the aforementioned areas cleaned up right away. CC-B added, just because the kitchen was old, it did not have to be dirty. On 02/03/2016, at 1:35 p.m.. the DD verified all of the aforementioned areas were not clean and sanitary which could have potentially caused a food born illness concern. The DD stated they had cleaning schedules and assignments set up and staff coming in tonight to clean. The DD further stated she would get the peeling paper	21015		

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21015	Continued From page 58 removed from the ceiling tiles, the food prep and other areas cleaned up right away. The DD stated the kitchen did not have anyone specific to do deep cleaning rather it was completed daily, after us. The DD stated maintenance and housekeeping were involved with night cleaning. The DD stated staff needed to do a better job of cleaning. The Department of Dietary - Department Cleaning Policy, updated 3/25/14, indicated the equipment, storage and work areas in the dietary department would be kept clean and safe for food handling, preparation and service. SUGGESTED METHOD OF CORRECTION: The director of dietary or designee could review and / or revise policies and procedures for ensuring sanitation of the kitchen. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/29/16

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21375	Continued From page 59 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control program which included consistent monitoring, trending, and analysis of infections to reduce the potential transmission to other residents in the facility. This had the potential to affect all 140 residents residing in the facility. In addition, the facility failed to ensure proper hand washing was completed for 1 of 1 resident (R183) who was observed to received wound care and for 1 of 8 residents (R68) who was observed to receive personal cares. Findings include: The facility infection control tracking sheets were reviewed from 11/2015, through 1/2016, and revealed the facility resident units were tracked on different tracking sheets. The individual unit sheets contained the following information: The facility Monthly Infection Report identified the following to be tracked for resident infections: - Name/Room - Admit Date - M.D. - Site - Cath SP or INDW [catheter, suprapubic or indwelling] - 3 Symptoms - Culture Date - Cultures results/ Organism, Colony Count - Med Ordered - Started Med - Stopped Med	21375	Corrected	

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21375	Continued From page 60 - Resolved - Ongoing The facility form Infection Tracking Log identified the following to be tracked for resident infections: - Date - Name - Unit/Room - Signs/ Symptoms - Onset Date - Culture Site - Culture Date - Culture Result - Infect or Colon [infection of colonized] - Isolation Precautions yes or no - Start Date - D/C Date [discontinued date] The November 2015, logs identified 35 resident infections. The logs did not consistently identify the signs and symptoms, documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, type or location of the unidentified infections and culture dates. The logs did not identify if the infections were community acquired or healthcare associated. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents. The December 2015, logs identified 51 resident infections. The logs did not consistently identify resident room numbers,signs and symptoms,	21375		

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documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, type or location of the unidentified infections and culture dates. The logs did not consistently identify if the infections were community acquired or healthcare associated. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents.

The January 2016, logs identified 35 resident infections. The logs did not consistently identify resident room numbers, signs and symptoms, documentation of onset and resolving of symptoms, and/or applicable cultures obtained to determine which organism was identified, type or location of the unidentified infections and culture dates. The logs did not consistently identify if the infections were community acquired or healthcare associated. Further, the listing did not identify any analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, and if education was needed for staff and/ or residents.

The February 2016 logs were unavailable for review.

When interviewed on 2/5/16, at 2:26 p.m. the director of nursing verified the units had not consistently documented on the same form with

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21375	Continued From page 62 all the required information or obtained all the needed information tracking, monitoring and canalizing of infections. A policy on the facility's infection control program tracking, monitoring and analysis was requested but not provided. R183 was observed to receive wound care services and the staff failed to ensure appropriate hand washing techniques were followed. On 2/3/16, at 10:56 a.m. licensed practical nurse (LPN)-D and nurse practitioner (NP)-A were observed to complete R183's wound care on R183's three pressure ulcers. LPN-D gathered supplies and with NP-A entered R183's room. R183 was lying in bed. NP-A and LPN-D washed their hands and NP-A donned a pair of gloves. LPN-D uncovered R183's feet and placed clean hand towels on the bed next to R183's feet along with skin barrier single use wipes and povidone-iodine disposable swabs. LPN-D removed the blue foam boot from R183's right foot and NP-A held R183's right foot off of the bed while LPN-D donned a pair of gloves. R183's right heel wound had no dressing on it. LPN-D measured the wound, cleansed the wound with normal saline, and patted the wound dry with a gauze pad. R185's right heel wound measured 2.7 centimeters (cm) in length by 2.8 cm in width and was unstageable (wound with full thickness tissue loss in which the base of the ulcer is completely covered with slough (dead tissue) or eschar (dry dark scab) in the wound bed). LPN-D removed her gloves and immediately donned a new pair of gloves. LPN-D applied skin barrier to	21375		

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the right heel wound, let it dry, and then painted the wound with the povidone-iodine swab. LPN-D removed her gloves and placed the foam boot back on R183's right foot. LPN-D proceeded to remove the foam boot on R183's left foot. R183's left heel wound had no dressing on it. LPN-D donned a new pair of gloves, irrigated the wound with normal saline, patted down the wound dry with a clean gauze pad and removed her gloves. LPN-D measured R183's left heel stage 2 wound to be 2.1 cm by 3 cm. LPN-D painted the wound with the povidone-iodine swab, removed the glove from her left hand, and then used her gloved hand to place the barrier wipe. LPN-D removed the remaining glove on her right hand and replaced the foam boot on R183's left foot. NP-A assisted LPN-D in assessing the wounds and elevated R183's feet during the wound care. LPN-D went into R183's bathroom and washed her hands. Registered nurse (RN)-B entered the room, washed her hands and donned a pair of gloves. LPN-D donned a new pair of gloves, gathered the soiled gloves and supplies from the window sill, placed them in the garbage, removed her gloves, and washed her hands. LPN-D donned a new pair of gloves, while NP-A and RN-B positioned R183 on his left side. LPN-D removed R183's dry brief and removed the dressing on R183's coccyx. LPN-D removed her gloves, immediately donned a new pair of gloves and measured R183's stage 2 coccyx wound to be 1.5 cm by 1.2 cm. LPN-D then irrigated the wound with normal saline, removed her gloves, donned a new pair of gloves, patted the coccyx wound dry with a gauze pad, and removed her gloves. LPN-D donned a new pair of gloves, applied the skin barrier wipe on the wound, and removed her gloves. Then using her bare hands placed a foam dressing over the coccyx wound. LPN-D, NP-A and RN-B removed their gloves and

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21375	Continued From page 64 washed their hands. On 2/3/16, at 11:32 LPN-D confirmed she had not washed her hands after removal of her gloves and between the wound cares on R183's heels, in addition she had used her bare hand and applied the foam dressing to R183's coccyx area. LPN-D stated she should have washed her hands. RN-B and NP-A did not disagree with this observation nor the need for LPN-D to wash her hands after the removal of gloves and in between wound care between wounds. The facility's Procedure for Clean Dressing Technique (undated) directed staff to wash their hands or use an alcohol based hand rub during wound care after each glove removal. R68 was observed receiving personal cares on 2/3/16, and staff did not performed appropriate hand washing techniques. On 02/03/2016, at 7:59 a.m. nursing assistant (NA)-D was observed to enter R68's room, raise the bed to a working height and uncovered R68 to get him up for the day. R68 was observed dressed in a shirt and incontinent brief. NA-D donned clean gloves and removed R68's incontinent brief which was wet. NA-D washed R68's groin utilizing a wipe and then rolled R68 to his right side and washed his bottom. A smear of feces was cleaned from R68's rectum. NA-D discarded the soiled brief and wipe into the garbage, applied a clean brief and assisted R68 into pants, socks and shoes. NA-D removed and discarded her gloves and placed a mechanical lift sling under R68. NA-E entered the room with a	21375		

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21375	Continued From page 65	21375		

mechanical lift and NA-D and NA-E attached the lift sling to the lift and transferred R68 to a wheelchair. NA-D removed the lift sling and attached a clip alarm to R68's chair and the back of his shirt. NA-D then placed R68's glasses on his face and without performing hand hygiene gathered supplies, placed toothpaste on a toothbrush and brushed R68's teeth. NA-D gave R68 a sip of water to rinse his mouth and put away the supplies. She then bagged the garbage, brought it to the soiled utility room and washed her hands.

On 02/03/2016, at 1:49 p.m. NA-D confirmed she had not performed hand hygiene after peri cares and prior to oral cares and should have done so.

On 02/05/2016, at 11:15 a.m. the DON confirmed hand hygiene should have been performed after peri cares and prior to oral cares.

The Hand Washing policy dated 4/1/2008, indicated the facility required staff to wash their hands after each direct resident contact for which hand-washing was indicated by accepted professional practice. The policy also directed hand-washing was to be conducted as per recommendations from the Center for Disease Control guidelines.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures for infection control monitoring and hand hygiene. Education could be provided to the staff. The quality

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21375	Continued From page 66 assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R23) was administered a step one tuberculosis skin test (TST) within 72 hours of admission or three	21426	corrected	3/29/16

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21426	Continued From page 67 months prior to admission. In addition the facility failed to ensure 1 or 5 residents (R213) was screened for tuberculosis and was administered a step one and step two TST. The facility also failed to ensure a date for the tuberculosis (TB) screening and administration of the step one TST was documented for 1 of 5 residents (R78). Findings include: R23's admission record indicated R23 was admitted to the facility on 11/20/15. R23's Baseline TB Screening Tool for Residents documented R23 to be screened for TB symptoms and administered the step one TST on 11/27/15, seven days after admission to the facility. R213's admission record indicated R213 was admitted to the facility on 1/22/16. R213's medical record lacked a Baseline TB Screening Tool for Residents containing a TB screen and a step one and step two TST administration on reading. R78's admission record indicated R78 was admitted to the facility on 8/6/15. R78's Baseline TB Screening Tool for Residents lacked a date the TB screening was conducted and the date the step one TST was administered. The facility policy Tuberculosis Screening for Chris Jensen Residents dated 4/16/12, indicated all residents will receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB screening must include an	21426		

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21426	Continued From page 68 assessment of the resident;s risk factors for TB, and any current symptoms. When interviewed on 2/5/16, at 2:57 p.m. the director of nursing stated she expected TB screening and testing would be done according to state guidelines, documented and kept in the residents record. Suggested Method for Correction: The administrator or designee could review and / or revise the facility system in place to ensure newly admitted residents receive screening of TB symptoms and the TST as required by state rule. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the TST and adjust the system as needed. Time Period for Correction: Twenty one (21) days	21426		
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	21530		3/29/16

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21530	Continued From page 69 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 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the consulting pharmacist identified the lack of an appropriate justification for the use of an antidepressant and / or antipsychotic for 2 of 6 residents (R153, R139) who received a routine dose of Trazadone or Seroquel, failed to ensure target behaviors and non pharmalogical interventions were developed, implemented and / or monitored to ensure efficacy of psychotropic medications for 3 of 6 residents (R153, R139, R136) who received as	21530	Corrected	

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21530	Continued From page 70 needed (PRN) antipsychotic medication and / or PRN antianxiety medication. In addition, the consulting pharmacist failed to identify the lack of a tapering dose reduction of an antidepressant had been attempted or contraindications of the reduction documented for 1 of 6 residents (R75) who had received a daily antidepressant without a trial dose reduction attempted. Findings include: R153 received a daily dose of Trazadone without an appropriate justification for use identified. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of the PRN Seroquel (antipsychotic). R153's Physician Order sheet dated 2/4/16, indicated R153 had diagnoses which included Parkinson's disease, chronic obstructive pulmonary disease (a lung condition), and Lewy Body dementia (an aggressive dementia which can cause hallucinations, rigid muscles, slowed movement and tremors). R153's quarterly Minimum Data Set (MDS) dated 11/21/15, indicated R153 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of psychosis nor behavior towards self or others, and received a daily dose of an antipsychotic and antidepressant medication. R153's Behavioral Symptoms Care Area Assessment (CAA) dated 9/2/15, indicated R153 had no hallucinations,	21530		

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21530	Continued From page 71 however, had shown signs of dementia and delirium. In addition, R153's Psychotropic Drug Use CAA dated 9/11/15, indicated R153 was taking an antipsychotic and an antidepressant medication. R153's care plan dated 11/25/15, identified a focus area for psychotropic drug use related to agitation with severe encephalopathy, severe Parkinsonism and Lewy body dementia which was initiated on 9/25/14. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, abnormal involuntary movement scale (AIMS) per facility policy and review for potential side effects. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN Seroquel. The care plan also identified a focus area for mood and behavior which indicated R153 displayed hitting and swearing with cares. The interventions included offer to walk the resident, leave the resident alone and return, try a different caregiver, try a different approach and offer apple juice. Fax Cover Letter to R153's physician dated 1/5/16, indicated R153 was currently taking four psychotropic medications: Med #1 - Seroquel Med #2 - Depakote sprinkles (medication to treat seizures or bipolar disease) Med #3 - Trazodone Med #4 - Neurontin (anticonvulsant medication) R153's physician indicated the target behaviors for all of these listed medications was "anxiety." In addition, the physician indicated the diagnoses	21530		

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21530	Continued From page 72 for justification for all these medications was "depression." R153's Target Behavior forms for 12/1/15 - 2/4/16, identified R153's target behavior as hitting and swearing at staff with cares. Approaches identified included secure others and resident safety and leave resident alone, wait ten minutes and return, try a different caregiver, speak calmly and slowly. R153's Medication Administration Record (MAR) for 12/1/15 - 2/4/16, was reviewed and indicated R153 had received Trazodone 75 mg daily. In addition, R153's MAR, nursing progress notes and behavior sheets were reviewed and revealed R153 received Seroquel 50 mg PRN 14 times from 12/1/15 - 2/4/16. The medical record lacked the following information related the use of the PRN Seroquel: -Documentation of target behaviors (hitting and swearing at staff with cares) six out of the 14 times 12/10/15, and 12/14/15 (R153 was given 3 doses on this day), 12/17/15, 12/20/15, 1/14/16) all lacked target behaviors resulting in the administration of the PRN medication. -Documentation of non-pharmacological interventions trialed prior to the administration of the PRN Seroquel eight out of 14 times on 12/7/15, 12/10/15, 12/14/15 (given three doses only documentation for one dose), 12/17/15, 12/19/15, 12/20/15, and 1/14/16. The consulting pharmacist's monthly medication regimen review for R153, from 7/7/15 - 1/26/16, lacked mention of the need for an appropriate diagnosis for the use of trazodone and the	21530		

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21530	Continued From page 73 identification and implementation of target behaviors and nonpharmacological interventions for the utilization of R153's PRN Seroquel. On 2/5/16, at 1:16 p.m. licensed practical nurse (LPN)-D verified R153 had PRN Seroquel ordered. LPN-D stated R153 usually received the PRN Seroquel four to five times a month when R153 exhibited behaviors such as hitting or punching staff. When asked about nonpharmacological interventions, LPN-D stated they could offer R153 apple juice, give him a ride in his wheelchair, however, LPN-D stated overall the staff could do a better job of documenting the target behaviors and nonpharmacological interventions. On 2/5/16, at 1:41 p.m. registered nurse (RN)-B confirmed the expectation was for staff to document the specific behavior exhibited by R153 and the nonpharmacological interventions trialed prior to the administration of the PRN Seroquel. In addition, target behaviors and nonpharmacological interventions should specifically be identified on the care plan. RN-B confirmed R153's care plan lacked these specifics. On 2/5/16, at 2:02 p.m. consulting pharmacist (CP)-A confirmed the depression diagnosis listed on the fax cover letter dated 1/5/16, for Seroquel, Depakote and Neurontin were not acceptable indications for use and anxiety listed as a target behavior was not specific. CP-A confirmed target behaviors and nonpharmacological interventions should be identified and implemented for R153's PRN Seroquel. CP-A confirmed the consultant	21530		

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21530	Continued From page 74 pharmacist's monthly medication regimen reviews included assuring appropriate diagnoses where identified for medication and that target behaviors and nonpharmacological interventions were identified and implemented for a PRN antipsychotic. R139 was routinely administered Seroquel without an appropriate diagnosis for it's use. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of PRN lorazepam (Ativan) (antianxiety). R139's Physician Order sheet dated 1/12/16, indicated R139 had diagnoses which included acute confusional state and dementia. R139's Integrated Problem List/Diagnostic Records, undated, indicated R139 was diagnosed with dementia with agitation. R139's's quarterly MDS dated 1/19/16, indicated R139 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R139's Behavioral Symptoms CAA dated 8/3/15, indicated R139 had shown signs of dementia and delirium. In addition, R139's Psychotropic Drug Use CAA dated 8/14/15, indicated R139 had dementia with agitation and was taking an antipsychotic medication.	21530		

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21530	Continued From page 75 R139's physician orders dated 1/12/16, included the following: -Quetiapine (Seroquel) 25 mg twice a day which was started 2/5/15. -Lorazepam 0.5 mg 1/2 tablet twice daily PRN which was started 11/30/15. R139's care plan dated 1/28/16, identified a focus area for psychotropic drug use due to Alzheimer's dementia. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, observe for lethargy and need for med reduction and complete the abnormal involuntary movement scale (AIMS) per facility policy. The care plan indicated R139 was noncompliant with care plan due to dementia and was at risk for effects related to refusal of medication, treatments and cares and directed staff to notify R139's physician, offer alternative to enhance compliance such as leave resident safe and reapproach, have another staff member approach, notify team lead as needed and to document refusals. The care plan also identified a focus area for mood and behavior which indicated R139 spent a great deal of time sitting in own room quietly. R139 experienced confusion with new things, wandered daily and had difficulty finding own room, and became agitated/frustrated when staff completed verbal assessments with her. The interventions included encourage to participate in planned activities, redirect as needed, conversation to calm and take to a quiet area. In addition, the care plan indicated R139 wandered aimlessly, was at risk for exit seeking and had impaired safety awareness and directed staff to assess for fall risk, code alert to ankle, monitor for fatigue and weight loss and provide	21530		

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21530	Continued From page 76 structured activities. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN lorazepam. The Fax Cover Letter to R139's physician dated 6/10/14, indicated last month a request for a diagnosis for Seroquel was sent with a reply of dementia with agitation to-control agitation. According to CMS (Centers for Medicare & Medicaid Services) guidelines, that is not an appropriate diagnosis. Please provide a different diagnosis for Seroquel and why. Response: This is off label-use of Seroquel for dementia with agitation. The Fax Cover Letter dated 2/3/16, which indicated R139's physician declined a dose reduction of the Seroquel due to a history of failed reduction with increased aggressive behaviors, wandering and resisted cares. R139's MAR indicated R139 utilized lorazepam 0.5 mg 1/2 tablet BID on 12/8/15, for restlessness/agitation, on 12/18/15, for anxiety/restless/wandering, on 1/1/16, for anxiety, 1/4/16, for anxiety, 1/9/16, was anxious,1/13/16, for refused PRN med prior to catheter use for a urine sample, 1/21/16, for anxiety and 1/30/16, due to wandering and refusing blood pressure assessment. R139's pharmacy reviews indicated no new recommendations during the 1/27/16, 12/15/15, and 11/5/15, pharmacy review.	21530		

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21530	Continued From page 77 R139's medical record lacked Target Behavior Forms. On 2/3/16, at 8:15 a.m. RN-E stated R139 had not utilized the PRN Ativan in February to date, but did use it in January. RN-E stated R139 was administered the PRN medication if she had increased anxiety. RN-E stated the use would be documented on the MAR and identified it was used for anxiety. RN-E stated she did not know what target behaviors or non-pharmacological interventions were to be attempted prior to administering the medication, therefore, had not documented such. RN-E stated R139's target behaviors nor interventions were not identified on the MAR. On 2/3/16, at 1:50 p.m. RN-D stated the diagnosis for the Seroquel use was dementia with agitation - to control agitation. RN-D provided and reviewed the 6/10/14, fax cover sheet and verified it had been submitted to R139's physician requesting an appropriate diagnosis for Seroquel. RN-D stated the physician did not change the diagnosis and stated she should not have to put her nursing license on the line to make sure a doctor did their job and she should not have to keep addressing the need for the diagnosis. RN-D stated she did not know what R139's target behaviors were or what non-pharmacological interventions were to be attempted. RN-D verified there was no information related to target behaviors or non-pharmacological interventions to be attempted prior to the administration of the PRN Lorazepam identified on R139's MAR or care plan.	21530		

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21530	Continued From page 78 On 2/3/16, at 2:03 p.m. the licensed social worker (LSW) stated target behaviors and non-pharmacological interventions should have been listed on R139's MAR right below lorazepam PRN was indicated. LSW stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the resident's target behaviors which should be identified on their individual MAR in order to monitor and implement interventions prior to the medication use. The LSW verified R139's medical record, care plan and MAR lacked target behaviors and non-pharmacological interventions to be attempted and stated they should be there, "I do not know why they are not." On 2/3/16, at 2:33 p.m. the DON verified target behaviors and non-pharmacological interventions should have been identified, monitored and attempted prior to administering R139's PRN lorazepam. In addition, the DON stated R139's care plan should have reflected the information as well. The DON stated it was her expectation staff would have identified target behaviors and attempted non-pharmacological interventions before administering the medication. On 2/5/16, at 2:12 p.m. CP-A confirmed the dementia diagnosis listed on the fax cover letter dated 6/10/14, for Seroquel, was not an acceptable indication for use. CP-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R139's PRN Lorazepam.	21530		

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21530	Continued From page 79 R136 was prescribed risperidone (Risperdal) (antipsychotic) PRN and target behaviors and non-pharmacological interventions were not consistently identified, trialed and monitored prior to the administration of the as needed (PRN) risperidone medication. R136's Integrated Problem List/Diagnostic Records sheet undated, indicated R136 had diagnoses which included dementia with paranoid thoughts, diabetes mellitus, and hyperlipidemia. R136's quarterly MDS dated 1/6/16, indicated R136 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R136's Psychotropic Drug Use CAA dated 8/3/15, indicated R136 was taking an antipsychotic medication. R136's physician orders dated 1/31/16 and 12/3/15, included the following: -Risperidone 0.25 mg twice a day which was started 8/7/14. -Risperidone 0.5 mg 1/2 tablet twice daily PRN started 1/9/15. R136's care plan dated, identified a focus area for psychotropic drug use. The interventions included medication as ordered, observe for medication effectiveness, abnormal involuntary	21530		

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21530	Continued From page 80 movement scale (AIMS) per facility policy. However, the care plan lacked identification of target behaviors and nonpharmacological interventions to be attempted prior to the administration of the PRN risperidone. The care plan also identified a focus area for mood and behavior which indicated R136 displayed wandering and became paranoid and believes others have stolen her belongings. R136 was easily redirected and directed staff to listen to concerns, redirect, encourage activities and to check for thirst, toileting pain and hunger. R136's MAR indicated R136 utilized Risperidone 0.5 mg 1/2 tablet on 1/5/16, and 1/8/16, for increased agitation and 1/9/16, for anxiety. No use in December 2015, and no use in February to date. R136's pharmacy reviews revealed the following: - 1/26/16, recommendations for reduction of omeprazole 20mg to 10mg (gastric medication) - 12/18/15, no recommendations - 11/8/15, no recommendations. On 2/3/16, at 11:15 a.m. R136 was observed in the dining room at an activity event. No behaviors observed. On 2/3/16, at 2:03 p.m. LSW-A stated target behaviors and non-pharmacological interventions should have been listed on R136's MAR right below the medication. LSW-A stated there are no behavior monitoring sheets for R136. LSW-A stated when a resident was prescribed an	21530		

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21530	Continued From page 81 antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which were then identified on the MAR for monitoring and implementation of interventions prior to PRN medication use. On 2/3/16, at 2:33 p.m. the DON verified target behaviors/nonpharmacological interventions should have been attempted prior to the administration of the medication and monitored. The DON stated R136's care plan should have also reflected that same information. The DON stated it was her expectation that staff would be attempting nonpharmacological interventions before administering the medication as well as target behaviors identified. On 2/4/16, at 10:56 a.m. RN-C stated R136 had not target behaviors or non-pharmacological interventions listed for the use of Risperidone. RN-C stated she had seen documentation on other resident MARs but not on R136's. RN-C stated she could list the interventions that worked for R136 and that they just were not written down, "I don't know why." RN-C stated she did not think R126 needed the PRN medication because she was easily redirected. On 2/4/16, at 1:59 p.m. RN-B stated target behaviors and non-pharmacological interventions should have been identified for R136. RN-B stated she would expect staff to attempt non-pharmacological's prior to administering PRN medication and document such. RN-B verified there were no target behaviors or non-pharmacological interventions found in R136's medical record or on the care plan.	21530		

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21530	Continued From page 82 On 2/4/16, at 2:30 p.m. R136 was observed sitting in her wheelchair visiting with her son. No behaviors observed. On 2/5/16, at 2:12 p.m. CP-A confirmed target behaviors and nonpharmacological interventions should have been identified, implemented and monitored for R136's PRN Risperidone use. R75 received a routine dose of an antidepressant medication (fluoxetine) without a tapering trial dose reduction attempted or contraindications for tapering documented. R75's quarterly MDS dated 12/23/15, indicated R75 was cognitively intact and had diagnoses which included stroke, anxiety disorder and dementia. The MDS also identified mood symptoms which included feeling down, depressed, or hopeless one day, feeling tired or having little energy nearly everyday and feeling bad about herself several days during the assessment period. The MDS further indicated R75 did not have hallucinations, delusions or any behavioral symptoms and exhibited no rejection of care of wandering and received antidepressant medication daily. R75's Psychotropic Drug Use CAA dated 9/25/15, indicated with the use of an antidepressant medication, R75 was at risk for undesirable side effects or aggravating signs and symptoms of existing conditions.	21530		

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21530	Continued From page 83 R75's Activities of Daily Living Functional/Rehabilitation CAA dated 9/25/15, indicated R75 had minimal symptoms of depression, felt down and bad about her situation, had poor sleep and a poor appetite. The CAA also indicated R75 was at risk for invalidism, diminished self worth, and a feeling of loss of control over one's own destiny. During interview on 2/2/16, at 11:14 a.m. R75 spent most of the time speaking with her eyes closed. R75's voice was tearful and her face was strained as she expressed concerns regarding her finances and paperwork, as well as concerns regarding her son and trusting the facility social workers regarding her bills. On 02/05/2016, at 9:39 a.m. R75 was observed seated at the edge of her bed dressed in a hospital style gown. No behaviors were observed. On 02/09/2016, at 8:36 a.m. R75 was seated at chair in Elm dining room at breakfast. RN-I attempted to give R75 her medication. R75 questioned what the pills were and refused to take them. On 02/09/2016, at 9:30 a.m. R75 remained seated at the table in the dining room, resting with here eyes closed. No behaviors observed. R75's Physician Orders dated 1/13/16, indicated R75 was prescribed fluoxetine 40 mg daily. The	21530		

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21530	Continued From page 84 orders indicate R75 was started on the medication 9/9/15 R75's Care Plan dated 12/23/15, identified a focus of psychotropic drug use and directed staff to administer medications as ordered, observe for medication effectiveness, symptoms of mood/behavior improvement or decline, observe for lethargy, need for medication reduction and to review observations with the physician. The Care Plan also directed staff to review medication potential side effects with the resident and/or person in charge of health care decisions for informed consents and review for possible medication reductions. Review of the Consultant Pharmacist's Medication Regimen Reviews identified the pharmacist reviewed R75's medication regimen on the following dates: 1/14/15, 2/26/15, 3/11/15, 4/15/15, 5/15/15, 6/12/15, 7/7/15, 8/10/15, 9/11/15, 10/7/15, 11/4/15, 12/16/15, and 1/22/16. -On 6/12/15, the pharmacist indicated R75 currently used fluoxetine 20 mg daily and recommended a dose reduction to 10 mg per day be considered to ensure the lowest effective dose was being used or if a reduction was not appropriate recommended documentation of the contraindication. R75's Physician Orders hand written order dated 9/9/15, indicated to increase fluoxetine to 40mg daily.	21530		

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21530	Continued From page 85 Review of R75's Physician Nursing Home Reports revealed the following: -7/8/15: She continues to be anxious, weepy. She is not really happy with her situation. The physician did not address the pharmacist recommendation to taper the dose of fluoxetine -9/9/15: She is alert, again weepy, anxious, agitated. Impression: progressive age-related and also vascular dementia, I think now with some confusion, some paranoid thought, some emotional lability. The physician did not provide a rationale for increasing fluoxetine from 20 mg to 40 mg daily. -11/11/15: She continues to be somewhat agitated. Medications are reviewed. She has been on fluoxetine 40 mg after her stroke. No further documentation regarding use of fluoxetine 40 mg daily. -1/13/16: voiced some increased anxiety. I think she would probably do better if we could find some task or duty that she could do, give her some value and in summary positive reinforcement. I encouraged staff to get her involved in activities. No further documentation regarding use of fluoxetine 40 mg daily. On 2/9/2016, at 10:54 a.m. RN-I confirmed R75 refused the fluoxetine and stated R75 had refused her fluoxetine the past 5 days. RN-F stated she had contacted the physician regarding the medication refusal. RN-F also stated R75's mood had been stable and she had been out of her room more since refusing the medication. However, she had been somewhat more suspicious of staff. On 2/9/2016, at 2:05 p.m. R75 stated she was	21530		

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21530	Continued From page 86 feeling much better. R75 stated her prescription for depression had been increased awhile ago but she didn't like how it made her feel. R75 stated she stopped taking it a few days ago and has felt better since then. R75's affect was bright and smiling. R75 stated she felt like a new person. On 2/9/2016, at 2:38 p.m. RN-F confirmed R75 was on fluoxetine when she was admitted to the facility over a year ago and a tapering of the medication had not been attempted. RN-F stated R75 had actually had an increase in the dosage of medication and verified there had not been a documentation of the rationale for the increase nor documentation of a contraindication for an attempted decrease of the medication. RN-F stated R75's mood had been more stable since refusing the medication. On 2/9/2016, at 2:58 p.m. RN-F stated after the pharmacist had reviewed the residents' medications she was emailed a list of his recommendations. RN-F indicated she would have expected the pharmacist to have requested a rationale for the increased dose of fluoxetine. Attempts to contact the consultant pharmacist were unsuccessful on 2/9/16 and 2/10/16. Medication Administration Record policy dated 3/1/14, indicated all medications would have a specific reason for use. Unnecessary Drugs-Antipsychotic Drugs policy dated 4/2009, indicated psychotropic drug	21530		

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21530	Continued From page 87 therapy should only be used when necessary to treat a specific condition as diagnosed and documented in the clinical record. In addition, prior to the administration of a PRN antipsychotic, justification of use must be documented in the medical record which included reasons why the medication was given and what nonpharmacological interventions were tried prior to administration. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to pharmacy reviews. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF 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	21540		3/29/16

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21540	Continued From page 88 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the appropriate justification for the use of an antidepressant and / or antipyschotic for 2 of 6 residents (R153, R139) who received a routine dose of Trazadone or Seroquel, failed to ensure target behaviors and non pharmalogical interventions were developed, implemented and / or monitored to ensure efficacy of psychotropic medications for 3 of 6 residents (R153, R139, R136) who received as needed (PRN) antipsychotic medication and / or PRN antianxiety medication without non-pharmocological interventions attempted prior to the administration of the medication. In addition, the facility failed to ensure a tapering dose reduction of an antidepressant was attempted or contraindications of the reduction documented for 1 of 6 residents (R75) who had received a daily antidepressant without a trial dose reduction attempted. Findings include: R153 was routinely administered Trazadone (antidepressant) without appropriate diagnoses.	21540	Corrected	

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21540	Continued From page 89 In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of the as needed (PRN) Seroquel (antipsychotic). R153's Physician Order sheet dated 2/4/16, indicated R153 had diagnoses which included Parkinson's disease, chronic obstructive pulmonary disease (a lung condition), and Lewy Body dementia (an aggressive dementia which can cause hallucinations, rigid muscles, slowed movement and tremors). R153's quarterly Minimum Data Set (MDS) dated 11/21/15, indicated R153 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of psychosis nor behavior towards self or others, and received a daily dose of an antipsychotic and antidepressant medication. R153's Behavioral Symptoms Care Area Assessment (CAA) dated 9/2/15, indicated R153 had no hallucinations, however, had shown signs of dementia and delirium. In addition, R153's Psychotropic Drug Use CAA dated 9/11/15, indicated R153 was taking an antipsychotic and an antidepressant medication. R153's physician orders dated 2/4/16, included the following: - Seroquel 50 mg (milligrams) twice a day which was started 5/22/15. - Seroquel 100 mg at bedtime which was started 7/8/15. - Seroquel 50 mg PRN up to three times a day which was started 9/15/14.	21540		

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21540	Continued From page 90 - Gabapentin (anticonvulsant medication) 100 mg three times a day which was started 10/14/14. - Trazodone (antidepressant) 75 mg daily started on 11/21/14. R153's care plan dated 11/25/15, identified a focus area for psychotropic drug use related to agitation with severe encephalopathy, severe Parkinsonism and Lewy body dementia which was initiated on 9/25/14. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, abnormal involuntary movement scale (AIMS) per facility policy and review for potential side effects. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN Seroquel. The care plan also identified a focus area for mood and behavior which indicated R153 displayed hitting and swearing with cares. The interventions included offer to walk the resident, leave the resident alone and return, try a different caregiver, try a different approach and offer apple juice. Fax Cover Letter to R153's physician dated 1/5/16, indicated R153 was currently taking four psychotropic medications: Med #1 - Seroquel Med #2 - Depakote sprinkles (medication to treat seizures or bipolar disease) Med #3 - Trazodone Med #4 - Neurontin (anticonvulsant medication) R153's physician indicated the target behaviors	21540		

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21540	Continued From page 91 for all of these listed medications was "anxiety." In addition, the physician indicated the diagnoses for justification for all these medications was "depression." R153's Target Behavior forms for 12/1/15 - 2/4/16, identified R153's target behavior as hitting and swearing at staff with cares. Approaches identified included secure others and resident safety and leave resident alone, wait ten minutes and return, try a different caregiver, speak calmly and slowly. R153's Medication Administration Record (MAR) for 12/1/15 - 2/4/16, was reviewed and indicated R153 had received Trazodone 75 mg daily. In addition, R153's MAR, nursing progress notes and behavior sheets were reviewed and revealed R153 received Seroquel 50 mg PRN 14 times from 12/1/15 - 2/4/16. The medical record lacked the following information related the use of the PRN Seroquel: -Documentation of target behaviors (hitting and swearing at staff with cares) six out of the 14 times 12/10/15, and 12/14/15 (R153 was given 3 doses on this day), 12/17/15, 12/20/15, 1/14/16) all lacked target behaviors resulting in the administration of the PRN medication. -Documentation of non-pharmacological interventions trialed prior to the administration of the PRN Seroquel eight out of 14 times on 12/7/15, 12/10/15, 12/14/15 (given three doses only documentation for one dose), 12/17/15, 12/19/15, 12/20/15, and 1/14/16. On 2/3/16, at 8:13 a.m. nursing assistant (NA)-J	21540		

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21540	Continued From page 92 was observed to utilize a sit to stand lift and assisted R153 into the bathroom. R153 took direction well and was not resistive to cares. On 2/4/16, at 2:43 p.m. R153 was observed seated in his tilt back wheelchair stationed on the outskirts of the nursing station. R153 was alert, calm and watched as other staff and residents passed by. On 2/5/16, at 1:16 p.m. licensed practical nurse (LPN)-D verified R153 had PRN Seroquel ordered. LPN-D stated R153 usually received the PRN Seroquel four to five times a month when R153 exhibited behaviors such as hitting or punching staff. When asked about non-pharmacological interventions, LPN-D stated they could offer R153 apple juice or give him a ride in his wheelchair. LPN-D stated overall, the staff could do a better job of documenting the target behaviors exhibited and non-pharmacological interventions attempted. On 2/5/16, at 1:41 p.m. registered nurse (RN)-B confirmed the expectation was for staff to document the specific behavior exhibited by R153 and the non-pharmacological interventions trialed prior to the administration of the PRN Seroquel. In addition, target behaviors and non-pharmacological interventions should specifically be identified on the care plan. RN-B confirmed R153's care plan lacked these specifics. On 2/5/16, at 2:02 p.m. consulting pharmacist (CP)-A confirmed the depression diagnosis listed	21540		

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21540	Continued From page 93 on the fax cover letter dated 1/5/16, for Seroquel, Depakote and Neurontin were not acceptable indications for use. In addition, anxiety listed as a target behavior was not specific. CP-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R153's PRN Seroquel. R139 was routinely administered Seroquel without an appropriate diagnosis for it's use. In addition, target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of PRN lorazepam (Ativan) (antianxiety). R139's Physician Order sheet dated 1/12/16, indicated R139 had diagnoses which included acute confusional state and dementia. R139's Integrated Problem List/Diagnostic Records, undated, indicated R139 was diagnosed with dementia with agitation. R139's's quarterly MDS dated 1/19/16, indicated R139 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R139's Behavioral Symptoms CAA dated 8/3/15, indicated R139 had shown signs of dementia and delirium. In addition, R139's Psychotropic Drug Use CAA dated 8/14/15, indicated R139 had dementia with agitation and was taking an antipsychotic medication.	21540		

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CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

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21540	Continued From page 94 R139's physician orders dated 1/12/16, included the following: -Quetiapine (Seroquel) 25 mg twice a day which was started 2/5/15. -Lorazepam 0.5 mg 1/2 tablet twice daily PRN which was started 11/30/15. R139's care plan dated 1/28/16, identified a focus area for psychotropic drug use due to Alzheimer's dementia. The interventions included medication as ordered, observe for medication effectiveness such as mood/behavior improvement or decline, observe for lethargy and need for med reduction and complete the abnormal involuntary movement scale (AIMS) per facility policy. The care plan indicated R139 was noncompliant with care plan due to dementia and was at risk for effects related to refusal of medication, treatments and cares and directed staff to notify R139's physician, offer alternative to enhance compliance such as leave resident safe and reapproach, have another staff member approach, notify team lead as needed and to document refusals. The care plan also identified a focus area for mood and behavior which indicated R139 spent a great deal of time sitting in own room quietly. R139 experienced confusion with new things, wandered daily and had difficulty finding own room, and became agitated/frustrated when staff completed verbal assessments with her. The interventions included encourage to participate in planned activities, redirect as needed, conversation to calm and take to a quiet area. In addition, the care plan indicated R139 wandered aimlessly, was at risk for exit seeking and had impaired safety awareness and directed	21540		

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21540	Continued From page 95 staff to assess for fall risk, code alert to ankle, monitor for fatigue and weight loss and provide structured activities. However, the care plan lacked identification of target behaviors and non-pharmacological interventions to be attempted prior to the administration of the PRN lorazepam. The Fax Cover Letter to R139's physician dated 6/10/14, indicated last month a request for a diagnosis for Seroquel was sent with a reply of dementia with agitation to-control agitation. According to CMS (Centers for Medicare & Medicaid Services) guidelines, that is not an appropriate diagnosis. Please provide a different diagnosis for Seroquel and why. Response: This is off label-use of Seroquel for dementia with agitation. The Fax Cover Letter dated 2/3/16, which indicated R139's physician declined a dose reduction of the Seroquel due to a history of failed reduction with increased aggressive behaviors, wandering and resisted cares. R139's MAR indicated R139 utilized lorazepam 0.5 mg 1/2 tablet BID on 12/8/15, for restlessness/agitation, on 12/18/15, for anxiety/restless/wandering, on 1/1/16, for anxiety, 1/4/16, for anxiety, 1/9/16, was anxious,1/13/16, for refused PRN med prior to catheter use for a urine sample, 1/21/16, for anxiety and 1/30/16, due to wandering and refusing blood pressure assessment. R139's pharmacy reviews indicated no new	21540		

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21540	Continued From page 96 recommendations during the 1/27/16, 12/15/15, and 11/5/15, pharmacy review. R139's medical record lacked Target Behavior Forms. On 2/3/16, at 8:15 a.m. RN-E stated R139 had not utilized the PRN Ativan in February to date, but did use it in January. RN-E stated R139 was administered the PRN medication if she had increased anxiety. RN-E stated the use would be documented on the MAR and identified it was used for anxiety. RN-E stated she did not know what target behaviors or non-pharmacological interventions were to be attempted prior to administering the medication, therefore, had not documented such. RN-E stated R139's target behaviors nor interventions were not identified on the MAR. On 2/3/16, at 1:50 p.m. RN-D stated the diagnosis for the Seroquel use was dementia with agitation - to control agitation. RN-D provided and reviewed the 6/10/14, fax cover sheet and verified it had been submitted to R139's physician requesting an appropriate diagnosis for Seroquel. RN-D stated the physician did not change the diagnosis and stated she should not have to put her nursing license on the line to make sure a doctor did their job and she should not have to keep addressing the need for the diagnosis. RN-D stated she did not know what R139's target behaviors were or what non-pharmacological interventions were to be attempted. RN-D verified there was no information related to target behaviors or non-pharmacological interventions to be attempted prior to the Adminstation of the	21540		

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21540	Continued From page 97 PRN Lorazepam identified on R139's MAR or care plan. On 2/3/16, at 2:03 p.m. the licensed social worker (LSW) stated target behaviors and non-pharmacological interventions should have been listed on R139's MAR right below lorazepam PRN was indicated. LSW stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the resident's target behaviors which should be identified on their individual MAR in order to monitor and implement interventions prior to the medication use. The LSW verified R139's medical record, care plan and MAR lacked target behaviors and non-pharmacological interventions to be attempted and stated they should be there, "I do not know why they are not." On 2/3/16, at 2:33 p.m. the DON verified target behaviors and non-pharmacological interventions should have been identified, monitored and attempted prior to administering R139's PRN lorazepam. In addition, the DON stated R139's care plan should have reflected the information as well. The DON stated it was her expectation staff would have identified target behaviors and attempted non-pharmacological interventions before administering the medication. On 2/5/16, at 2:12 p.m. CP-A confirmed the dementia diagnosis listed on the fax cover letter dated 6/10/14, for Seroquel, was not an acceptable indication for use. CP-A confirmed target behaviors and non-pharmacological interventions should have been identified and implemented for R139's PRN Lorazepam.	21540		

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21540	Continued From page 98 R136 was prescribed risperidone (Risperdal) (antipsychotic) PRN and target behaviors and non-pharmacological interventions were not consistently identified and trialed prior to the administration of the as needed (PRN) risperidone medication. R136's Integrated Problem List/Diagnostic Records sheet undated, indicated R136 had diagnoses which included dementia with paranoid thoughts, diabetes mellitus, and hyperlipidemia. R136's quarterly MDS dated 1/6/16, indicated R136 had severe cognitive impairment, required extensive assist with activities of daily living, showed no signs of delirium (acute confusional state) nor behavior towards self or others, had trouble concentrating and received a daily dose of an antipsychotic medication. R136's Psychotropic Drug Use CAA dated 8/3/15, indicated R136 was taking an antipsychotic medication. R136's physician orders dated 1/31/16 and 12/3/15, included the following: -Risperidone 0.25 mg twice a day which was started 8/7/14. -Risperidone 0.5 mg 1/2 tablet twice daily PRN started 1/9/15. R136's care plan dated, identified a focus area for psychotropic drug use. The interventions included medication as ordered, observe for	21540		

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21540	Continued From page 99	21540		

medication effectiveness, abnormal involuntary movement scale (AIMS) per facility policy. However, the care plan lacked identification of target behaviors and nonpharmacological interventions to be attempted prior to the administration of the PRN risperidone. The care plan also identified a focus area for mood and behavior which indicated R136 displayed wandering and became paranoid and believes others have stolen her belongings. R136 was easily redirected and directed staff to listen to concerns, redirect, encourage activities and to check for thirst, toileting pain and hunger.

R136's MAR indicated R136 utilized Risperidone 0.5 mg 1/2 tablet on 1/5/16, and 1/8/16, for increased agitation and 1/9/16, for anxiety. No use in December 2015, and no use in February to date.

R136's pharmacy reviews revealed the following:
- 1/26/16, recommendations for reduction of omeprazole 20 mg to 10 mg (gastric medication)
- 12/18/15, no recommendations
- 11/8/15, no recommendations.

On 2/3/16, at 11:15 a.m. R136 was observed in the dining room at an activity event. No behaviors observed.

On 2/3/16, at 2:03 p.m. LSW-A stated target behaviors and non-pharmacological interventions should have been listed on R136's MAR right below the medication. LSW-A stated there are no behavior monitoring sheets for R136. LSW-A

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21540	Continued From page 100 stated when a resident was prescribed an antianxiety or antipsychotic medication, she reviewed and determined the target behaviors which were then identified on the MAR for monitoring and implementation of interventions prior to PRN medication use. On 2/3/16, at 2:33 p.m. the DON verified target behaviors/nonpharmacological interventions should have been attempted prior to the administration of the medication and monitored. The DON stated R136's care plan should have also reflected that same information. The DON stated it was her expectation that staff would be attempting nonpharmacological interventions before administering the medication as well as target behaviors identified. On 2/4/16, at 10:56 a.m. RN-C stated R136 had not target behaviors or non-pharmacological interventions listed for the use of Risperidone. RN-C stated she had seen documentation on other resident MARs but not on R136's. RN-C stated she could list the interventions that worked for R136 and that they just were not written down, "I don't know why." RN-C stated she did not think R126 needed the PRN medication because she was easily redirected. On 2/4/16, at 1:59 p.m. RN-B stated target behaviors and non-pharmacological interventions should have been identified for R136. RN-B stated she would expect staff to attempt non-pharmacological's prior to administering PRN medication and document such. RN-B verified there were no target behaviors or non-pharmacological interventions found in	21540		

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21540	Continued From page 101 R136's medical record or on the care plan. On 2/4/16, at 2:30 p.m. R136 was observed sitting in her wheelchair visiting with her son. No behaviors observed. On 2/5/16, at 2:12 p.m. CP-A confirmed target behaviors and nonpharmacological interventions should have been identified, implemented and monitored for R136's PRN Risperidone use. R75 received an antidepressant medication (fluoxetine) and a tapering dose reduction was not attempted or contraindications for tapering documented. R75's quarterly MDS dated 12/23/15, indicated R75 was cognitively intact and had diagnoses which included stroke, anxiety disorder and dementia. The MDS also identified mood symptoms which included feeling down, depressed, or hopeless one day, feeling tired or having little energy nearly everyday and feeling bad about herself several days during the assessment period. The MDS further indicated R75 did not have hallucinations, delusions or any behavioral symptoms and exhibited no rejection of care of wandering and received antidepressant medication daily. R75's Psychotropic Drug Use Care Area Assessment (CAA) dated 9/25/15, indicated with the use of an antidepressant medication, R75 was at risk for undesirable side effects or aggravating signs and symptoms of existing	21540		

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21540	Continued From page 102 conditions. R75's Activities of Daily Living Functional/Rehabilitation CAA dated 9/25/15, indicated R75 had minimal symptoms of depression, felt down and bad about her situation, had poor sleep and a poor appetite. The CAA also indicated R75 was at risk for invalidism, diminished self worth, and a feeling of loss of control over one's own destiny. During interview on 02/2/16, at 11:14 a.m. R75 spent most of the time speaking with her eyes closed. R75's voice was tearful and her face was strained as she expressed concerns regarding her finances and paperwork, as well as concerns regarding her son and trusting the facility social workers regarding her bills. On 02/05/2016, at 9:39 a.m. R75 was observed seated at the edge of her bed dressed in a hospital style gown. No behaviors were observed. On 02/09/2016, at 8:36 a.m. R75 was seated at chair in Elm dining room at breakfast. RN-I attempted to give R75 her medication. R75 questioned what the pills were and refused to take them. On 02/09/2016, at 9:30 a.m. R75 remained seated at the table in the dining room, resting with here eyes closed. No behaviors observed.	21540		

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21540	Continued From page 103 R75's Physician Orders dated 1/13/16, indicated R75 was prescribed fluoxetine 40 mg daily. The orders indicate R75 was started on the medication 9/9/15 R75's Care Plan dated 12/23/15, identified a focus of psychotropic drug use and directed staff to administer medications as ordered, observe for medication effectiveness, symptoms of mood/behavior improvement or decline, observe for lethargy, need for medication reduction and to review observations with the physician. The Care Plan also directed staff to review medication potential side effects with the resident and/or person in charge of health care decisions for informed consents and review for possible medication reductions. Review of the Consultant Pharmacist's Medication Regimen Reviews identified the pharmacist reviewed R75's medicaiton regimen on the following dates: 1/14/15, 2/26/15, 3/11/15, 4/15/15, 5/15/15, 6/12/15, 7/7/15, 8/10/15, 9/11/15, 10/7/15, 11/4/15, 12/16/15, and 1/22/16. On 6/12/15, the pharmacist indicated R75 currently used fluoxetine 20 mg daily and recommended a dose reduction to 10 mg per day be considered to ensure the lowest effective dose was being used or if a reduction was not appropriate recommended documentation of the contraindication. R75's Physician Orders hand written order dated 9/9/15, indicated to increase fluoxetine to 40 mg daily.	21540		

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21540	Continued From page 104 Review of R75's Physician Nursing Home Reports revealed the following: -7/8/15: She continues to be anxious, weepy. She is not really happy with her situation. The physician did not address the pharmacist recommendation to taper the dose of fluoxetine -9/9/15: She is alert, again weepy, anxious, agitated. Impression: progressive age-related and also vascular dementia, I think now with some confusion, some paranoid thought, some emotional lability. The physician did not provide a rationale for increasing fluoxetine from 20 mg to 40 mg daily. -11/11/15: She continues to be somewhat agitated. Medications are reviewed. She has been on fluoxetine 40 mg after her stroke. No further documentation regarding use of fluoxetine 40 mg daily. -1/13/16: voiced some increased anxiety. I think she would probably do better if we could find some task or duty that she could do, give her some value and in summary positive reinforcement. I encouraged staff to get her involved in activities. No further documentation regarding use of fluoxetine 40 mg daily. On 02/09/2016, at 10:54 a.m. RN-I confirmed R75 refused her senna (a laxative) and fluoxetine and stated R75 had refused her fluoxetine the past 5 days. RN-F stated she had contacted the physician regarding the medication refusal. RN-F also stated R75's mood had been stable and she had been out of her room more since refusing the medication. However, she had been somewhat more suspicious of staff. On 02/09/2016, at 2:05 p.m. R75 stated she was feeling much better. R75 stated her prescription	21540		

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21540	Continued From page 105 for depression had been increased awhile ago but she didn't like how it made her feel. R75 stated she stopped taking it a few days ago and has felt better since then. R75's affect was bright and smiling. R75 stated she felt like a new person. On 02/09/2016, at 2:38 p.m. RN-F confirmed R75 was on fluoxetine when she was admitted to the facility over a year ago and a tapering of the medication had not been attempted. RN-F stated R75 had actually had an increase in the dosage of medication and verified there had not been a documentation of the rationale for the increase nor documentation of a contraindication for an attempted decrease of the medication. RN-F stated R75's mood had been more stable since refusing the medication. Medication Administration Record policy dated 3/1/14, indicated all medications would have a specific reason for use. Unnecessary Drugs-Antipsychotic Drugs policy dated 4/2009, indicated psychotropic drug therapy should only be used when necessary to treat a specific condition as diagnosed and documented in the clinical record. In addition, prior to the administration of a PRN antipsychotic, justification of use must be documented in the medical record which included reasons why the medication was given and what nonpharmacological interventions were tried prior to administration.	21540		

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21540	Continued From page 106 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to uneccessary medication use. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF 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 consistently contained a label to ensure safe administration on 3 of 8 medication carts. In addition the facility failed to consistently ensure medications with a shortened expiration date after opening were labeled with the date the medication was opened on 4 of 8 medication carts. Findings include: During observation of the west Birch medication cart on 2/4/16, at 2:13 p.m. with registered nurse (RN)-C two, in use, Advair Diskus inhalers lacked resident labels to identify resident name, pharmacy information, medication, directions for use and date filled. Both Advair Diskus' lacked a	21620	Corrected	3/29/16

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21620	Continued From page 107 date when they were opened. In addition one Symbicort inhaler was not dated when opened and had a fill date of 8/21/15. RN-C stated the Advair come in a bag or box with the label attached but did not know where the bag/box for the medication was located. When interviewed on 2/4/16, at 2:19 p.m. RN-F verified Symbicort expired three months after opening and the Advair Diskus should have been stored with packaging that included the prescription label. During observation of the Willow medication cart on 2/4/16, at 3:02 p.m. with licensed practical nurse (LPN)-E one Flovent inhaler lacked a resident label to identify resident name, pharmacy information, medication, directions for use and date filled. LPN-E verified the Flovent did not have a label attached and the packaging for the medication was not on the cart. During observation of the east Cedar medication cart on 2/5/16, at 8:56 a.m. with trained medication assistant (TMA)-A one, in use, Symbicort inhaler was not dated when the medication was opened. The fill date for the Symbicort was 9/15/15. TMA-A verified the Symbicort was not dated when the medication was opened. During observation of the west Cedar medication cart on 2/5/16, at 9:05 a.m. with LPN-D one Novolog Flex Pen (insulin medication to control diabetes) was found to have a torn label and could not identify resident name, pharmacy	21620		

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CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

(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
21620	Continued From page 108 information, medication, directions for use and date filled. The Novolog Flex Pen also lacked a date in which the insulin pen was opened. In addition another Novolog Flex Pen with a fill date of 10/17/15, was opened and lacked a date when the medication was opened. LPN-D verified both Novolog flex pens were opened and lacked documentation when the insulin was opened and one Novolog Flex Pen's label was torn off. The manufacturers package insert for Advair Diskus directed to throw away Advair Diskus in the trash one month after opening. The manufacturers package insert for Symbicort directed to throw away Symbicort when the counter reached zero or three months after opening. The manufacturers package insert for Novolog flex pen directed to dispose of the pen 28 days after opening. When interviewed on 2/05/16, at 2:21 p.m. the director of nursing stated medications are to be stored with their label and medications with an expiration date after opening were to be dated when opened. The facility's policy Medication Labeling dated 3/1/14, included labels are to include the resident's name, drug name, dose, frequency, route instructions for use and expiration date.	21620		

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21620	Continued From page 109 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to medication labeling requirements. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF 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 review, the facility failed to maintain the kitchen in a clean and sanitary manner. In addition, the facility failed to ensure an electric wheelchair was in good repair for 1 of 1 resident (R133) who utilized an electric wheelchair. Findings include: On 2/1/16, at 4:02 p.m. an initial tour of the kitchen was done with the dietary director (DD).	21685	Corrected	3/29/16

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21685	Continued From page 110 On 2/3/16, at 1:27 p.m. a revisit tour was also conducted with the DD and the corporate consultant (CC)-B and the following concerns were observed: -The floor around the large floor mixer was rusty with debris and black grime around the bottom of the mixer stand. The DD stated the area would be cleaned right away. -The large stove and ovens had grease and black grime build up around the outer edges of ovens, on the stove. The triple stacked ovens had greasy, sticky grime build up on the doors and handles. The glass windows were dirty with food spills. The DD stated staff only used the upper and lower oven as the middle oven was out of order and had been for a long time. -The kitchen floor had food debris, the outer edges of the entire perimeter of the kitchen and around all equipment and storage areas including the food prep area were observed to dirty with black, thick substances built up. The DD verified the floors were dirty with build up and it was not clean. -Cooler #1- the floor was dirty with a black grimy substance. The DD stated this would be mopped and cleaned at the end of the day. -Cooler #5- milk storage, there were dried white milk spills on the inside door and the walls on the left upon entering had milk spills. The DD verified the area was not clean. -The large commercial toaster on the bread and sandwich station counter had sticky, grime build up. The DD verified the side and front of the toaster was not clean.	21685		

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21685	Continued From page 111 -The 4 double door dry storage cabinets doors/handles had black, grime substance on them. The DD stated she would have them cleaned. The range hood above the cook stove has three panels which had dust and debris build up. The DD stated this was scheduled to be cleaned shortly as it was usually done every two weeks. -The fruit and vegetable prep counter cabinets had black grime on the doors and handles and dirty tape residue. The old cooler below the counter for the salad cold food prep area, was dirty with food debris, grime and rust. The cabinet and the doors were off and the side shelves were used for large can storage. The DD verified the areas were not clean and she was not sure what happened to the cabinet doors. -The timer knobs for the Steamcraft ultra steamer which was used for cooking, were missing. The DD stated staff just used the manual switch and would frequently check the foods as they were unable to set the timer knobs. The DD stated the knobs had been broken for over a year and she was unsure of what the plan was for the steamer as the knobs may have been too costly to replace. The DD verified walls by steamer and stove were dirty with grime, dust and food debris. -The DD verified the Vulcan convection oven had grime built up on doors handles and knobs. -The DD verified all of the garbage/trash receptacles had built up food debris and grime on them and were in need of cleaning. -The shelf the microwave sat on was missing	21685		

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21685	Continued From page 112 laminate on the left/right side which had a sticky substance on edges of shelf where laminate was. -The wall pillar between the dirty dish and clean dish area had a two foot by three foot section of peeling paint. The DD verified this should have been taken care of. On 02/03/2016, at 10:59 a.m. CC-B stated the kitchen was on the facility's remodel list to be completed after the remodeling of resident rooms was completed. The CC-B agreed the kitchen needed to be cleaned and stated staff would be getting the aforementioned areas cleaned up right away. CC-B added, just because the kitchen was old, it did not have to be dirty. On 02/03/2016, at 1:35 p.m.. the DD verified all of the aforementioned areas and equipment were not clean and sanitary. The DD stated they had cleaning schedules and assignments set up and staff coming in tonight to clean the equipment and areas. The DD stated she was aware of the plan to update of the kitchen but was just was not sure when. The DD stated the kitchen did not have anyone specific to do deep cleaning rather was completed daily, after us. The DD stated maintenance and housekeeping were involved with night cleaning. The DD stated staff needed to do a better job of cleaning. The Department of Dietary - Department Cleaning Policy, updated 3/25/14, indicated the equipment, storage and work areas in the dietary department would be kept clean and safe for food handling, preparation and service.	21685		

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21685	Continued From page 113 R133's electric wheelchair was not maintained in good repair. On 02/02/2016, at 09:10 a.m. R133's electric wheelchair was observed. The hard plastic control panel, located on the right arm of the wheelchair, was scraped, marred and pock-marked for approximately 3 inches along the right outer edge. The right upper surface of the control panel was smudged with white ash. The head rest was covered with black duct tape along the side edges, top edge and posterior surface. The back cushion was covered with black duct tape along the entire sides of the cushion from approximately 2 inches above the arm rest to the head rest. The posterior of the back cushion was covered in 4 strips of black duct tape placed side by side starting at the edge of the chair and covering the surface of the cushion to the head rest, on both sides. The left corner of the seat cushion had an approximate 1 inch cut in the covering, exposing the inner foam cushion. On 02/09/2016, at 2:48 p.m. registered nurse (RN)-F stated R133 resident had talked to her about needing a new chair. RN-F stated R133 was worried about the financial aspect of obtaining a new chair but was unaware if social services was working with her regarding the chair. RN-F indicated repairs for a wheel were made last week, however verified there was no chair on order. RN-F stated R133's chair was pretty banged up and dinged up. RN-F confirmed the back and head rest cushions were covered in duct tape. and the control panel on the right arm	21685		

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21685	Continued From page 114 rest was nicked and marred. On 02/9/16, at 5:07 p.m. the maintenance director(MD) stated the maintenance department was responsible for maintaining residents' wheelchairs. MD confirmed they had applied the duct tape to R133's wheelchair and stated they probably needed to do it again. No policy regarding wheelchair maintenance was provided. SUGGESTED METHOD OF CORRECTION: The director of dietary or designee could review and / or revise policies and procedures for ensuring kitchen equipment was maintained. In addition, the director of nursing or designee could review and / or revise policies and procedures related to the maintenance of resident care equipment. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plans. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means	21810		3/29/16

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21810	Continued From page 115 care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a table adequate for dining for 1 of 2 residents (R133) observed to eat meals in her room without a table for placement of her meal. Findings include: R133's quarterly Minimum Data Set (MDS) dated 12/20/15, indicated R133 was cognitively intact and was independent with eating. R133's care plan dated 10/13/2015, indicated R133 could feed herself and directed staff to arrange place setting, apply condiments, cut meat, pour liquids and encourage R133 to finish meal as directed by resident. On 02/03/2016, at 8:41 a.m. R133 was observed eating breakfast in her room. A tray with a napkin, coffee cup and knife were observed on the bed while R133 sat in her electric wheelchair which facing the bed. R133 was balancing a plate inside a plate warmer on her chest, holding them with her left hand, while eating a waffle with her right hand. A half eaten bowl of hot cereal was observed on top of the closed lid of a	21810	Corrected	

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21810	Continued From page 116 commode which was at R133's the bedside. R133 stated she could use a table for her tray but thought they were all being used. An over the bed table was observed against the wall across the room from R133's bed. A lamp and decorations were placed on top of the over the bed table. On 02/03/2016, at 12:51 p.m. R133 was observed eating lunch in room. Her lunch tray with plate, utensils, glass of fluid and napkin was placed on R133's bed. R133 stated she liked to eat in her room as she enjoyed watching television during her meal. A half full coffee cup was observed placed on the closed lid of a commode at R133's bedside. Several dried coffee cup rings were observed on the lid of the commode. On 02/05/2016, at 8:51 a.m. R133 was observed eating breakfast in her room. The breakfast tray was placed on the bed. On 02/05/2016, at 9:56 a.m. nursing assistant (NA)-R was observed picking up resident breakfast trays. NA-R stated R133 often ate in her room, used her bed for her meal tray and that R133 liked to have her tray placed on her bed. NA-R confirmed R133 put items from her meal tray on the commode and stated the practice was not sanitary. On 02/05/2016, at 9:58 a.m. R133 stated she would like to have a table for her meal tray and stated she was scared she would spill on the bed.	21810		

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21810	Continued From page 117 On 02/05/2016, at 10:49 a.m. registered nurse (RN)-F confirmed R133 should be provided a table for her meal tray and placing items on the commode was not sanitary. RN-F indicated there were tables available for R133's use. On 02/05/2016, at 11:30 a.m. the director of nursing (DON) confirmed R133 should have a table to use for her meal tray. The Accommodation of Needs policy dated 4/1/2008, indicated a resident had the right to reside and receive services in the facility with reasonable accommodations for individual needs and preferences, except when safety of the individual or other residents would be endangered. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures for ensuring appropriate table height for all residents. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21810		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults	21980		3/29/16

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21980	Continued From page 118 Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision	21980		

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21980	Continued From page 119 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report bruises of unknown origin to the State agency for 2 of 5 residents (R78, R180) reviewed for abuse prohibition and found to have bruises of unknown origin not reported the State agency. Findings include: R78's bruise of unknown origin was not immediately reported to the SA. The Resident Incident Report, completed by licensed practical nurse (LPN)-C on 12/29/15, indicated R78 was noted to have a very large bruised area under the right arm just below the right elbow, through the axilla area extending down and engulfing most of the right breast and also down into ribs. R78 was also noted to have a greater than 10 centimeter (cm) bruise to the top of her left hand. The bruised areas were of unknown origin. R78 was described as not in pain unless her breast area was touched. The incident report indicated the physician and family were notified on 12/29/15. The report did not identify when the administrator was notified, however the administrator signed the report on 1/11/16. The Vulnerable Adult Reporting section	21980	Corrected	

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21980	Continued From page 120	21980		

of the incident report identified an "x" placed next to the "No" choice for Reported to CEP [common entry point].

R78's Interdisciplinary Note dated 12/29/15, indicated R78 was found with bruising to the right side of her body with very dark bruising starting from just below elbow up through axilla area, extending down under arm and engulfing most of her right breast. The note also indicated R78 had bruising to the top of her left hand. The note indicated the physician and director of nursing (DON) were notified and investigation started as the bruise was of unknown origin.

On 02/05/2016, at 11:32 a.m. the DON verified the bruises were identified on 12/29/15, at 12:25 a.m. and the unit manager investigated the incident when she came on duty for the morning shift. The DON confirmed the bruises were of unknown origin and should have been reported to the SA immediately but had not been reported at all.

R180 was noted to have a bruises of unknown origin which were not reported to the SA, as required.

A Resident Incident Report completed by registered nurse (RN)-A on 7/13/15, indicated R180 was noted to have a 9.0 cm by 5.0 cm bruise to the upper left arm. R180 did not complain of pain and was identified as being "unreliable" to report how the bruise had occurred. The rest of the incident report was blank.

R180's The Nurse's Record & Progress Notes dated 7/13/15, at 2:00 p.m. indicated a 5.0 cm x

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CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

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21980	Continued From page 121 9.0 cm bruise was noted on R180's left arm. The note also indicated R180 was unable to communicate when the bruise occurred. No further investigation of the bruise was noted in the clinical record. A Resident Incident Report completed on 12/2/15, indicated R180 was found to have a 4.0 cm x 4.5 cm bruise on the center / mid back and a 7.0 cm x 7.0 cm bruise on the left hip. The report indicated the bruises were of unknown origin, R180 denied pain and was unable to state how or when she had received the bruises. The RN supervisor section indicated R180 had been more ambulatory and may have fallen. R180's The Nurse's Record & Progress Notes dated 12/9/15, at 2:00 p.m. identified the 9.0 cm x 5.0 cm bruise on R180's left arm. The note also indicated R180 was unable to communicate when the bruise occurred. On 2/3/16, at 12:50 p.m. RN-A verified R180's bruises were of unknown origin. She stated when bruises of unknown origin were identified, she completed an incident report regarding the bruises. She stated she was unaware if the bruises had been reported to the State Agency. She also stated she did not know how to report concerns to the SA as the only employees who reported concerns to the SA were the licensed social worker and the DON. On 2/3/15, at 1:42 p.m. the DON verified the aforementioned bruises were of unknown origin and should have been reported to the SA, as required.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIS JENSEN HEALTH & REHABILITATION C	2501 RICE LAKE ROAD DULUTH, MN 55811

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21980	Continued From page 122 The Abuse Prevention/Resident Treatment policy dated 4/1/08, defined abuse as the willful infliction of injury with resulting physical harm and physical abuse to include hitting, slapping, pinching and kicking. The policy indicated an injury should be classified as an "injury of unknown source" if the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy directed all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property were to be reported immediately to the administrator of the facility and were also to be reported immediately to the SA in accordance with existing state law. The facility investigated each alleged violation thoroughly and reported the results of all investigations to the administrator as well as to SA's as required by stated and federal law. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and / or revise the policies and procedures for reporting, educate the staff on what is reportable and to immediately report to the administrator and the state agency. The administrator of designee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21980		