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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 477C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00989

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245097**

2.STATE VENDOR OR MEDICAID NO.
(L2) **332668000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FARIBAULT CARE CENTER**
(L4) **1738 HULETT AVENUE NORTH**
(L5) **FARIBAULT, MN** (L6) **55021**

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) **01/01/2011**

6. DATE OF SURVEY **05/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Supervisor — 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 06/09/2014 (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
01/12/1967
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/08/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5097

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 03/13/14. On 05/05/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 04/24/14, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 03/13/14, effective 05/23/14. Refer to the CMS-2567B for both health and life safety code.

Effective 05/23/14, the facility is certified for 55 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5097

June 9, 2014

Ms. Shelley Solberg, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

Dear Ms. Solberg:

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

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

Effective May 23, 2014, the above facility is certified for:

55 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 21, 2014

Ms. Shelley Solberg, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

RE: Project Number S5097024

Dear Ms. Solberg:

On April 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 24, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 24, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2014, effective May 23, 2014 and therefore remedies outlined in our letter to you dated April 8, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245097	A. Building B. Wing	5/5/2014

Name of Facility	Street Address, City, State, Zip Code
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0174** Reg. # **483.10(k),(l)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **04/22/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/22/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/22/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	05/21/2014	16022	05/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245097	A. Building B. Wing	5/5/2014

Name of Facility	Street Address, City, State, Zip Code
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0406** Reg. # **483.45(a)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/22/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/22/2014**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	05/21/2014	16022	05/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/13/2014

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245097	A. Building 01 - MAIN BUILDING 01 B. Wing	4/24/2014

Name of Facility	Street Address, City, State, Zip Code
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/22/2014	ID Prefix Reg. # NFPA 101 LSC K0154	04/22/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	05/21/2014	12424	04/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/13/2014

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: 477C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00989

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245097**

2.STATE VENDOR OR MEDICAID NO.
(L2) **332668000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FARIBAULT CARE CENTER**
(L4) **1738 HULETT AVENUE NORTH**
(L5) **FARIBAULT, MN** (L6) **55021**

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) **01/01/2011**

6. DATE OF SURVEY **03/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Candace Bolduc, HFE NE II 04/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 04/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/12/1967
(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.
00320
(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: 24-5097

At the time of the standard survey completed March 13, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. In addition, at the time of the survey MDH completed an investigation of complaint number H5097061 that was found to be unsubstantiated. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7475

April 8, 2014

Ms. Shelley Solberg, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

RE: Project Number S5097024 and Complaint Number H5097061

Dear Ms. Solberg:

On March 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5097061. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5097061 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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 signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 24, 2014 (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 24, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 03/31/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245097	A. BUILDING _____ B. WING _____	C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(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	F 000	This plan of correction is submitted as required under Federal and State laws. The submission of this Plan of Correction does not constitute an admission on the part of Faribault Care Center as to the accuracy of the surveyors' findings or the conclusions drawn there from. The Plan of Correction also does not constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on this basis. The Facility submits this plan of correction with the intention that it be inadmissible by any third party against the Facility or any employee, agent, officer, director, attorney, or shareholder of the Facility or affiliated companies.	
F 164 SS=D	The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. " An investigation of complaint H5097061 was completed. The complaint was not substantiated. 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	4/22/14 SER	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelley Sellers | TITLE: Administrator | (X6) DATE: 04/17/14

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

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal privacy during cares for 1 of 3 residents (R25) observed for incontinence and the facility failed to confidentially post personal information for 1 of 4 residents (R46) observed smoking. Findings include: R25 lacked privacy during incontinence cares. During an interview on 3/11/14 at 9:12 a.m. R25 stated staff did not pull curtains or close doors to provide privacy during cares. R25 was observed during incontinence cares provided by nursing assistant (NA)-J and trained medication aide (TMA)-E on 3/12/14 between 1:30 p.m. and 1:50 p.m. During the cares R25 was observed to urinate on the bed linens. TMA-E was observed to open the door and leave the room without pulling the privacy curtain or providing personal privacy to R25 who was lying in bed exposed. TMA-E reentered the room	F 164	F164 1. R46 has been discharged from the facility. Confidential personal information that was posted in a public area of facility was removed.R25 is deceased. 2. All staff have been educated regarding appropriate provision of privacy. Smoking schedule will remain as it is for any resident who smokes-resident information will not be placed on the smoking schedule. Education completed 3/25/2014 3. Director of Nursing/Designee will provide education to all staff related to the posting of personal information and policy and procedure for providing privacy during cares and promoting resident dignity. 4. 3 residents will be monitored weekly x 4 wks then 1 resident per week for 3 months for privacy infringements. Monitoring will be completed by SDC, Administrator and DON and or designee. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 164	Continued From page 2 again. No privacy curtain was pulled and no personal privacy was provided to R25. TMA-E was interviewed at 1:50 p.m. and stated the privacy curtain should have been pulled before she exited the room. During an interview on 3/13/14 at 11:45 a.m. the director of nursing stated privacy was an expectation of care. R46 lacked confidentiality of personal smoking information. On 3/10/14 at 5:30 p.m. a sign was observed posted in the nursing area/dining room/resident activity area that stated [R46's name in bold typing] Smoking Schedule. The sign listed the times and mount of cigarettes R46 could smoke During an interview on 3/10/14 at 5:11 p.m. R46 stated the cigarettes were locked up and felt rights were taken away. R46 was observed on 3/12/14 at 7:10 p.m., on 3/13/14 at 7:35 a.m. outside to smoke under staff supervision. Each time R46 was observed to ask staff to be able to smoke. Review of documents identified the facility completed a smoking assessment on 2/6/14 that stated the resident required supervision, had cognitive loss, and had been observed smoking in bedroom or bathroom. The facility elopement risk assessment dated 2/6/14 noted under smoking, "will jump fence if given a chance". No assessment/ analysis of data was provided.	F 164		

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F 164	Continued From page 3 Review of the care plan printed, 2/18/14, had a focus related to smoking The interventions directed the resident required visual supervision while smoking, that cigarettes and lighter were to be locked up. During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she was aware R46 had smoking issues and that a smoking schedule had been implemented because R46 had wanted to go outside to smoke frequently and needed supervision because of elopement risk. DON stated the posting of the smoking schedule in a public area was a dignity issue.	F 164		
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure privacy during telephone usage for 1 of 1 (R46) residents observed using the telephone. Findings include:	F 174	F174 1.R46 has been discharged from the facility, Staff will move residents to private location when they are requiring a private phone conversation. 2. Social Service Designee/designee will complete an audit with each resident to ensure they have a private place to talk on the telephone. 3. Social Service Designee/designee will educate all staff 04/17/2014 on providing a private place for residents to have a private phone conversation. 4. Social Service Designee/designee will monitor telephone privacy through resident council monthly. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 174	Continued From page 4 R46 was not provided privacy during phone calls. During an interview on 3/10/14 at 5:11 p.m. R46 stated not allowed to use the portable telephone and felt rights were taken away. " Make me sit here as a good boy " . R46 was observed on 3/12/14 at 10:05 a.m. sitting in the hallway using the telephone in the nursing station. Three staff and three residents were within hearing distance. On 3/12/14 at 10:19 a.m. R46 stated the telephone call was to be private because it was to a health care provider. R46 stated did have a cell phone, but that the use of the cell phone cost money. On 3/12/14 between 1:00 p.m. and 3:00 p.m. R3 was observed to use the telephone at the nursing station four times. When asked, resident stated these phone calls were not private. Review of documents indicated R46 was admitted to the memory care unit on 11/5/13. The admission Minimum Data Set (MDS) dated 11/5/13 indicated the resident had a brief interview of mental status score (BIMS) of 13 or no cognitive impairment, displayed no behaviors, and was independent with all activities of daily living. A sign was posted outside the memory care unit. The sign stated, " Resident phone is not allowed on Memory Lane until further notice. Thank you." During an interview on 3/13/14 at 12:10 p.m., the director of nursing verified no portable telephone was available in the memory care unit. DON stated it was her understanding that R46 would use the telephone for hours and not allow other	F 174		

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F 174	Continued From page 5 residents to use the phone. DON verified the incident of being at the nursing station with staff in area was a privacy issue, but added the resident could use personal cell phone. During an interview with the social service designee (SSD) on 3/13/14 at 1:00 p.m., SSD verified the portable phone was not to be used in the memory care unit. SSD stated R46 was told that the nursing station phone was available for use. SSD stated R46's guardian did not want R46 to have access to the portable phone to call her. SSD stated the phone at the nursing station was not private.	F 174		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 6 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63) in the sample who reported allegations of abuse. In addition, the facility failed to ensure these residents were protected from potential retaliation while an investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, during an initial observation and interview on 3/10/14, at 5:00 p.m., R12 stated, "I think they	F 225	F225 1. Social Service Designee spoke with Residents #1, 12, 16, 59 63, and 70 to identify if the grievances have been resolved. 2. All Unusual Occurrences in the last 30 days were reviewed by DON/Admin to identify if any other injuries of unknown origin should be reported to the State Agency. 3. Policy and Procedure for reporting was reviewed by DON with all staff on 03/25/2014 to ensure all occurrences are reported and investigated timely by administrator/ designee. 4. All Unusual Occurrences will be reviewed weekly by Interdisciplinary Team/designee to ensure proper communication, investigation, and reporting has occurred weekly or until a lesser time is deemed appropriate. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 225	Continued From page 7 need better training in respect and dignity which I consider to be abusive here." When asked to further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, "Yah, what do you want? You should be able to do it yourself!" R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 stated not being confident staff are passing on the information. R12 was observed to have a frustrated facial expression. R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact. A review of the resident council minutes from December 2013 under the section "Old Business" read "Don't appreciate the evening CNA's (certified nursing assistant) coming in saying they are tot busy to help" This concern was addressed by R12. Upon review of the form titled "Resident/Family Grievance/Concern Form" for	F 225		

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F 225	Continued From page 8 R12's statement read, "During resident council when asked, are you being treated with dignity and respect, she responded Not always and said was told, I have 30 patients today, don't give me any grief." R12 did not know who it was, only that it was in the evening and it was a CNA. Reported to Administrator 11/7/13. The administrator wrote on the form that she interviewed two nursing assistants and they both denied the allegation. The facility was unable to produce any documentation, investigation or staff education regarding R12's grievance. R1's BIMS dated 2/20/13, indicated a summary score of 5 out of a possible 15 for cognitive patterns indicating severe impairment. Review of the December resident council meeting minutes, the question was asked, Do you feel you are treated with dignity and respect and R1 was quotes, "Some of them, evening doesn't help you." During an initial observation and interview on 3/11/14, at 2:09 p.m. when asked has anyone here abused you R1 stated Yes and further stated, "Verbal abuse has happened, I have been yelled at for needing help and have asked about it at the resident council." R1 is not aware of the disposition for her complaint and validated she continues to have concerns for abuse and stated, "Sometimes they get upset with me and will scold me for calling out for help." The facility was unable to produce any documentation, investigation or staff education regarding R1's grievance expressed from the resident council November 2013.	F 225		

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F 225	Continued From page 9 R70, during an initial observation and interview on 3/11/14 ,at 1:29 p.m. when asked about abuse R70 stated, "I have heard the staff bark at residents and will say, I was just in here, what do you want." R70 said that administration has been informed and he has told "The powers that be, that people get yelled at or scolded here." R70 further expressed a feeling that residents are scolded and reprimanded for asking for things and then he feels the residents are "Shunned!" R70 mentioned the ladies across the hall from him have been verbally abused from the staff and stated, "people are in pain here, people are afraid to ask to go to the bathroom because they will get yelled at, I have heard it and reported it." R70 was observed to have an angry expression when responding to the question. R70's BIMS dated 2/18/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact. The facility was unable to produce any grivance or concern documantation, investigation or education regarding R70's grievance. R59's documents were reviewed and upon reviewing a form titled Resident/Family Grievance/Concern dated 2/18/14, by R59 read, "Resident asked for his pills staff went off on him. Stated 'everyone always wants these pain pills. I feel like a drug rehab. Then said I should just get out the cards and let them just take them.' Resident showed his stomach and said if you had this it would hurt. She stated I've had worse problems." The Response /Internal investigation by facility staff member read, "Reviewed	F 225		

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F 225	Continued From page 10 concerns with staff involved and did staff education regarding verbalizing frustration and respectfulness is resident infraction." When interviewed on 3/13/14, at 1:15 p.m., R59 verified the staff member was disrespectful and did not want to have anymore conversation about the situation. R59's BIMS dated 2/19/4, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact. The facility was unable to produce any documentation, investigation or staff education regarding R59's grievance. R16 expressed a grievance during a resident council meeting November 2012, and read, "Last week in the evening he was in bed and a Chinese lady came into his room and twisted his leg. Resident could not give day or time this happened. The internal investigation in summary read, the writer called staff at home, who referred to residents legs being tangled in the sheet, moved his legs, but he refused to get up, brief was wet, aide changed him in bed by moving his knees to roll him over. R16 BIMS dated 8/25/13, indicated a summary score of 12 out of a possible 15 for cognitive patterns indicating moderate impairment. The facility was unable to produce any documentation, investigation or staff education regarding R16's grievance.	F 225		

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F 225	Continued From page 11 R63 had a grievance concern which read, "Had a problem with [NA-Z], She was rude and abusive to me, she said, 'I shouldn't have to do this everyday,' It was her tone, terrible attitude." R63 thought the incident was at night on Sunday. R63 requested care and the staff member did nothing. The response to the grievance read, "Talked to NA-Z, she does not remember being this way, she is not rude but factual." R63 BIMS dated 11/12/13, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact. The facility was unable to produce any documentation, investigation or staff education regarding R63's grievance. A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation from any other source regarding the protection, investigation, education or training	F 225		

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F 225	Continued From page 12 on abuse related to the specific grievances for R12, R1, R70, R59, R16 or R63 and stated, "I don't know why they weren't reported as verbal abuse." The administrator thought the grievances were dealt with but could not produce any documentation to coincide with the resident complaints. The administrator validated the resident complaints were verbal abuse and should have been reported to the State Agency. The administrator validated the residents should have been protected pending investigation of the verbal abuse and the abuse prevention plan was not implemented for these residents.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement established policies and procedures to protect residents who reported allegations of potential abuse, thoroughly investigate allegations of abuse and immediately report allegations of potential abuse to the facility's administrator and state agencies for 6 of 8 residents (R1, R12, R16, R59, R63, R70) in the sample who reported allegations of abuse. Findings include: R1, R12, R16, R59, R63 and R70 reported an	F 226		

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F 226	Continued From page 13 allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agency. . A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. with the administrator, she was unable to produce any further documentation from any other source regarding the protection, investigation, education or training on abuse related to the specific grievance for R1, R12, R16, R59, R63 or R70 and stated, "I don't know why they weren't reported as verbal abuse." The administrator thought the grievances were dealt with but cannot produce any documentation to coincide with the resident complaints. The administrator validated the resident complaints were verbal abuse and should have been reported to the State Agency. The administrator validated the residents should have been protected pending investigation of the verbal abuse and the abuse prevention plan was not implemented for those residents.	F 226	F226 1. Social Service Designee spoke with Residents #1, 12, 16, 59 63, and 70 to identify if the grievances have been resolved. Abuse prevention plan will be followed and all accusation of abuse will be reported to the state agency. 2. Audit completed of all staffs knowledge of Unusual Occurrence/Abuse Neglect Policy and Procedure by administrator/designee. 3. All staff educated on 3/25/14 Unusual Occurrence/ Abuse Neglect reporting and investigating by administrator/designee. 4. Administrator/designee will complete random staff audits to ensure knowledge of Unusual Occurrence/Abuse Neglect Policy and Procedure. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244		
	When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances related to answering of the call lights for 6 of the 43 residents (R12, R2, R31, R53, R58, R28) who resided in the facility who expressed concern with call lights being answered. Findings include: R12 stated; during an initial interview on 3/10/14, at 5:00 p.m., "I think they need better training in respect and dignity which I consider to be abusive here." When asked to further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, Yeh, what do you want? You should be able to do it		F244 1.Resident(s) #2, 12, 28, 31, 53, and #58 concerns were addressed and follow up was completed. 2. Social Service Designee/designee will complete an audit of complaints/grievances made during resident council for the last 30 days. 3. Administrator/designee educated Social Service Designee 04/17/2014 on policy and procedure for completing complaints/grievances. 4. Administrator /designee will review resident council meeting notes to ensure all complaints/grievances have been filed and followed through on weekly with weekly grievance review. 5. Any concerns identified will be addressed through the Quality Assurance meetings 6. The facility will be in substantial compliance by 04/2202014	4/22/14

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F 244	Continued From page 15 yourself! R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 is not confident staff are passing on the information. Review of R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact. The resident council meeting minutes were reviewed and documentation included: (1) 3/6/14, several concerns regarding call lights were brought up such as R12 expressing staff coming into the room, whip off the call light and then leave and don't come back. R2 said, You have your call light on, they come in and shut it off and say they will be back, they have someone else to take care of, and this happens more than once, I can have my call light on for a half hour to an hour. R31 said, call lights are generally worse during the evening. R58 was concerned about having to wait on the toilet so long. (2) 2/6/14, concerns were expressed regarding meal times and call lights continue to be an issue according to R2, R12 and R31. (3) 1/2/14, R31 When asked about the call light response time R31 expressed, will they ever be answered, so few,(two) people working, takes 40 minutes. Meal times there is no one around to answer lights.	F 244		

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F 244	Continued From page 16 R53 agreed and commented Yes, takes half an hour. R13 expressed Staff needs to slow down, they want to throw you together and get out of there, some cares require more time (4) 12/5/13, R53 commented it took half an hour to forty five mnutes to answer the call light. R28 referred to issues with call lights after 2:00 p.m. R12 referred to a resident who was yelling out for the bell, she didn't have her call light near her. R31 said half the time the CNA (certified nursing assistants) are not reporting my request to the TMA (trained medication aide). Documentation was lacking to indicate the concerns recommendations expressed during the resident council meetings had been acted upon and discussed with the residents to assure the grievances had been remedied. During interview on 3/13/14, at 9:15 a.m. with the activity director (AD) it was confirmed that residents concerns expressed at resident council meetings are to be documented on a grievance form by the department involved. Call lights would be the director of nursing (DON)responsibility although all staff were responsible to answer resident call lights. The AD passes the meeting minutes on to the department heads and they are to process a grievance form. The DON had attended the December and January resident council meetings and informed residents audits were being conducted of the resident call light response times, and that a memo was posted to staff. The DON did not attend the February and March resident council meetings but answered the resident concerns of the call lights not being	F 244		

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F 244	Continued From page 17 answered timely by referring to the audits that were ongoing and a memo being posted to the staff regarding answering call lights. The AD verified the residents continiued to express serious concern with the answering of the call lights and were becoming increasingly frustrated because answering of the call lights has been a concern for many months. During an interview on 3/13/14, at 8:30 a.m. with R2 regarding resident council and concerns expressed at resident council, she stated, " I put my light on and they shut it off mostly on the evening shift. They are short of help all the time, they rush along and say we gotta go now, you get sick of it." R2 further expounded on concerns being brought up at resident council and stated, "It constantly continues to happen, why can they get by with this, I have incontinence, I have been told there is no one to help me. I have pooped in my pants two months ago waiting for someone to come. Now I have learned to call on the phone to the desk for help. I tell the nurses but I don't know what is happening with my complaints." Document revoew pf R2's Brief Interview for Mental Status (BIMS) dated 1/20/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact. During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation to validate the resident specific concerns expressed were investigated and/or a follow up discussed to their satisfaction with the resident. The administrator stated, "We have missed a step in the process."	F 244		
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246		

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F 246 SS=D	Continued From page 18 OF NEEDS/PREFERENCES	F 246		
	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 ensure the use of functioning hearing aides for 1 of 2 residents (R4) observed with hearing aides. Findings include: During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide or why the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m.,		F246 1.Resident #4 Hearing aid was found immediately when it was reported missing, hearing aidwas in working order. 2. Director of Nursing/designee will complete an audit of all residents with hearing aides to assure they are in use and battery size identified 3. Director of Nursing/ educated staff 03/25/2014 on assisting residents with hearing aides and checking to ensure there are functional. 4. Direct Care Staff will check hearing aide batteries daily 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 246	Continued From page 19 R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide last week. R4's active diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. R4's Brief Interview for Mental Status (BIMS) dated 12/30/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." The interventions read, "I want my hearing aids left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and	F 246		

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F 246	Continued From page 20 theft policies of the facility. I wear bilateral hearing aids. I can put them in and take them out independently. I will ask for assist if I need, especially with taking battery out." An intervention on the plan of care dated 10/25/13, read "Staff again attempted to have resident allow hearing aides kept in nurses cart for safe keeping. Resident rejected the offer. Because of history of losing hearing aides, staff will not remove anything from residents room without first assuring hearing aides are accounted for." The consultation report from audiology dated 7/16/13, under recommendations read, "Need plan from nursing home of how future loss of hearing aids will be prevented before patient is fit with replacement. Return in 2 weeks for a hearing aide fitting." The consultation report from audiology dated 9/3/13, read "1. Continue wearing both aides daily. 2. Replacing both batteries weekly, early if needed (the left uses the size 13 or orange and right uses size 675 or blue). 3. Turn hearing aids off when not in use by opening battery doors. 4. Return in 4 months for a hearing aide recheck, sooner if there are problems." A document titled Audiology office visit and dated 10/4/13, read "The right hearing aide had a size 13 battery in it instead of the 675. The tubing was twisted on both hearing aides. The batteries were replaced in both hearing aids. The tubing was replaced. Both hearing aides are working fine now." In review of the medication and treatment sheets for March 2014, there was no area addressing the tracking of the bilateral hearing aides. The nursing assistant assignment sheet read, "Hearing Aides." but did not designate the battery size for which ear, nor did the assignment sheet	F 246		

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F 246	Continued From page 21 direct staff to account for the hearing aides.	F 246		
F 272 SS=D	Attempts to call the resident family were unsuccessful to discuss the hearing aides and the medical record director (MRD) validated the family was difficult to get hold of as neither had answering machines or message capabilities. The MRD did not know if the family was aware of the right hearing aide being missing. 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;	F 272	F272 1. Resident #45 has been discharged. R45 was referred to the secured unit related to significant flight risk. Resident has been discharged from facility. 2. Any resident that is either referred internally or externally for the secured unit will be assessed by SSDfor appropriate placement. 3. Current residents on the secured unit have been reviewed by SSD for appropriate placement. 4. Prior to admission to the secured unit, residents will be reviewed by SSD for the criteria specific to the secured unit. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 272	Continued From page 22 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess 1 of 1 residents (R46) for appropriateness of placement in the dementia/memory care unit at the time of admission. Findings include: R46 lacked an assessment for the appropriateness of placement on the locked dementia unit. R46 was admitted to the locked dementia unit on 11/5/14 directly from an acute care hospital. The initial Preadmission Screening (PAS) dated 11/5/13 indicated R46 needed behavior management or instruction, was resistant to redirection, and had a history of homelessness.. During an interview on 3/10/14 at 5:06 p.m. R46 stated he was only 50 and felt this was not an appropriate placement. The care conference summary dated 11/25/13 indicated R46 had stated he did not want to be " locked up "	F 272		

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F 272	Continued From page 23 The admission Minimum Data Set (MDS) dated 11/12/13 noted R46 had a BIMS (brief interview for mental status) score of 13/15 or no cognitive impairment. The MDS noted R46 displayed no hallucinations, no delusional behaviors, no physical or verbal behaviors, displayed no rejection of care, and displayed no wandering behaviors. The care plan had a problem dated 11/6/13 of placement at the Faribault Care Center was appropriate for long term care; on the secured unit; an elopement risk; had a history of leaving facilities to look for alcohol. The care plan did not include interventions related to re-assessment for continued placement on the locked dementia unit. Review of the documentation revealed no elopement attempts had occurred since admission. During an interview on 3/10/14 at 6:30 p.m. the administrator (ADM) stated that she was not sure why R46 was in the dementia unit except because he was an elopement risk. ADM stated she did not think this was an appropriate placement. During an interview on 3/13/14 at 12:10 p.m. the direct of nursing (DON) stated she believed R46 could climb out even with the locked fenced area. DON added she would like to see R46 in an age appropriate facility. During an interview on 3/13/14 at 1:00 p.m. the social service designee stated she was not able to find any social services documentation related to dementia unit placement for R46.	F 272		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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	245097	A. BUILDING _____ B. WING _____	C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(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 279 SS=D	Continued From page 24 COMPREHENSIVE CARE PLANS	F 279		
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care for 2 of 3 residents (R40, R70) identified as a fall risk, failed to develop a plan of care that included non-pharmacological interventions for 2 of 5 residents (R40, R27) reviewed for unnecessary medications. Findings include: R70 experienced three, unwitnessed falls, in his bedroom. The falls occurred on 3/5/14, at 12:53		F279 1.R70 was discharged from the facility to assisted living facility, R40 care plan was reviewed and updated as needed. R27 parameters have been added to care plan as well as non-pharmacological interventions. 2. Director of Nursing/designee will complete an audit of all care plans to ensure that falls and non-pharmacological interventions for unnecessary medications have been addressed. 3. Director of Nursing/designee educated 03/25/14 all nursing staff on updating careplans. 4. Interdisciplinary Team will monitor all careplans with any change in condition, quarterly and with annual assessment. 5.If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 279	Continued From page 25 a.m., on 3/6/14, at 6:45 p.m. and on 3/9/14 at 11:07 a.m. Review of the plan of care for R70 with an initiation date of 1/10/14, and a revision date of 1/20/14 revealed that there were no goals or interventions addressing falls or falls with fracture. R70's active diagnosis from the minimum Data Set (MDS) form dated 1/16/14, lists but is not limited to, hypertension, anxiety and muscle weakness. The MDS further indicated a history of falls with fracture 2-6 months prior to admission. The Care Area Assessment addresses falls as a risk for R70. R70's Brief Interview for Mental Status (BIMS) dated 1/16/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact. When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date	F 279		

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F 279	Continued From page 26 initiated 1/14/2014) did not address the resident's history of falls and did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care plan (on admission) should have addressed falls with interventions since the resident had a history of falls. R27's plan of care did not address parameters for use of an anti-anxiety medication and did not address use of non-pharmacological interventions prior to the administration of anti-anxiety medications. R27 was on multiple scheduled psychotropic medications, which were not addressed on the plan of care. R27 Admitted 2/3/2014 with dx (from care plan) altered mental status, traumatic amputation of toes, sedative/hypnotic /anxiolytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal reflux, opioid type dependence abuse, dissociative identity disorder, drug-induced psychotic disorder with hallucinations, paranoid schizophrenia, A physician order dated 2/3/2014 identified R27 on Clonazepam 0.5 mg twice daily as needed for severe anxiety. The other scheduled psychoactive medications were Buspar, Elavil,	F 279		

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F 279	Continued From page 27 Zyprexa, and Trilafon.	F 279		
	Medication sheets dated 2/2014 and 3/2014 were reviewed. The resident used the as needed clonazepam (antianxiety medication) several times in both months. The scheduled other psychotropic medications were given as ordered. R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The care plan lacked documentation regarding the use of the as necessary anti-anxiety medication and did not address what non pharmacological interventions were to followed before giving the as needed anti anxiety medication. The clinical record also lacked documentation of non-pharmacological interventions attempted prior to the administration of as necessary antianxiety medication. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of as necessary (prn) antianxiety medication and stated that non pharmacological interventions should be attempted prior to the as needed anti anxiety medication. DON stated the care plan should have been developed to identify the use of the prn medication and the non pharmacological interventions. R40's care plan did not address the use of as needed antianxiety medication for sleep and anxiety, monitoring, and use of non-pharmacological interventions prior to administration of the medication. A Discharge summary from the hospital dated			

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F 279	Continued From page 28 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed. R40 admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder, paralysis agitans, compression of brain, parkinson's disease, hx of alcohol use, intracerebral hemmorrhage, obstructive hydrocephalus, insomnia (on MD notes 1/29/2014) A physician order dated 1/16/2014 identified Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety; and Lorazepam 0.5 mg (4 tabs of 2 mg.) by mouth at bedtime as needed for sleep. R40's medication sheets were reviewed: Lorazepam (antianxiety medication) was used as necessary for sleep and/or anxiety: 1/14--9 times; 2/14- was used 23 times and in 3/14-it was used 8 times. A sleep evaluation, dated 1/13/2014, was reviewed. It identified the resident had difficulty staying asleep; related to pain; did not have a history of taking sleep medications routinely prior to bedtime. An average length of nap was 1-2 hours. R40 had neurological deficits (stroke, Parkinson's disease, seizure disorder). No environmental factors contributing to resident sleeping difficulties was identified. The assessment was a collection of data but did not contain a summary or analysis of the data to determine a plan. R40's care plan with initiated date of 1/14/2014 and print out date of 2/20/2014 was reviewed. It did not address R40's sleep issues or use of as	F 279		

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F 279	Continued From page 29 needed antianxiety medications. The care plan lacked documentation regarding what non pharmacological interventions should be attempted before giving the as needed anti anxiety medication. The clinical record also lacked documentation of non-pharmacological interventions to be attempted prior to the administration of medication. On 3/13/2014 at 11:45 a.m., a trained medical assistant (TMA)-C was interviewed regarding use of the antianxiety medication. TMA-C indicated she did not give the medication during the day and indicated R40 was given the medication at night for sleep. TMA-C stated the resident got anxious but rarely used it throughout the day because the resident was up and about. The TMA did not know if there was criteria to use prior to giving the medication. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the DON was interviewed regarding criteria for use of antianxiety medication. She stated they should be using non pharmacological interventions prior to administering the medication and should also be following up for effectiveness. DON also checked for sleep monitoring for R40 and indicated it was not being done, DON said that the sleep plan for R40 was not based on sleep assessment data.	F 279		
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	F 282		

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F 282	Continued From page 30 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 ensure the care plan was followed for 1 of 3 residents (R25) observed with urinary incontinence and 1 of 3 residents (R4) who required assistance with hearing aides. Findings include: R25 did not receive incontinence care in accordance with the plan of care. During three observations incontinence care exceeded the 2 hours as noted in the care plan. The care plan printed 2/13/14 was reviewed. The care plan had a focus of, "staff assist with toileting" and directed staff to offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 pm to 7:30 p.m.R25 was observed to be lying on his back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/12/14 R25 was observed from 10:25 a.m. to 1:30 p.m. R25 was not observed to be provided continence cares for 3 hours. Nursing assistant (NA)-J stated she had last repositioned and assisted R25 at 10:00 a.m. or a total of 3.5 hours. R25 was observed on 3/12/13 at 12:00 p.m. to 1:30 p.m. At 1:30 p.m. R25 received incontinence care (by observation 1.5 hours) NA-J stated she had last provided cares	F 282	F282 1.R25 is deceased, R4 hearing aid was found immediately when it was reported missing, hearing aid was in working order. 2. Interdisciplinary Team will audit all direct care care plans to ensure they are accurate for activities of daily living. 3. Director of Nursing/designee educated 03/25/2014 all staff on following the direct care careplan. 4. Director of Nursing/designee will complete weekly random audits to ensure staff is proving care as directed on direct care careplan. 5.If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 282	Continued From page 31 to R25 at 10:00 a.m. (a total of 3.5 hours) On 3/13/14 R25 was observed from 7:09 a.m. to 8:58 a.m. and no incontinence cares were provided. NA-C stated she had worked all night and had last changed and repositioned R25 at 5:30 a.m. (greater than 3.5 hours). The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated she would expect the care plan to be followed. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to receive incontinence cares. R4 did not receive assistance with hearing aides and batteries according to the plan of care. Review of R4's plan of care dated 12/3/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide or why the one in the left ear was not working. When asked how do you communicate NA-B	F 282		

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F 282	Continued From page 32 shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m. R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1:00 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. On 3/13/14 at 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide last week.	F 282		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)	F 285		

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F 285	Continued From page 33 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a Preadmission Screening and Resident Review (PSARR) Level II	F 285	F285 1. R46 has been discharged, R27 Social Service Designee has called the Senior Linkage Line for further assessment 2. The Social Designee will complete audits of all new admissions within last 90 days to determine the required PSARR has been completed 3. Social Service Designee has been educated 04/17/2014 regarding the requirements related to the PSARR 4. Social Service Designee will complete audits of all new admissions 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014 4/22/14	

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F 285	Continued From page 34 evaluation was completed for 2 of 3 residents (R46, R27) reviewed with mental illness/developmental disabilities. Findings include R46 lacked a PSARR level II evaluation on admission. R46 was admitted on 11/5/13 from an acute care hospital to the facility ' s locked dementia unit. R46's diagnoses listed on the preadmission screening dated 11/5/13 as Karsakoff dementia (alcohol induced dementia) and bipolar disease. The initial Pre-Admission Screening (PAS) was submitted on November 5, 2013 by Senior LinkAge Line The PAS noted OBRA Level I Result as: " Based on the information provided for this nursing home stay, it appears this person meets the criteria for MI and needs to be referred to the lead agency for further evaluation. " The administrator was interviewed on 3/13/14 at 3:05 p.m. and stated that she had no further PSARR screening information and was presently calling the county to ask for a level II screening. R27 lacked a PSARR level II evaluation on admission. R27 was admitted to the facility on 2/3/2014, and had diagnoses listed on the preadmission screening dated 2/3/2014 as altered mental status, and schizophrenia. The initial Pre-Admission Screening (PAS) was submitted on February 3, 2014 by Senior LinkAge ALine. The PAS noted OBRA Level I Result as: "	F 285		

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F 285	Continued From page 35 Based on the information provided for this nursing home stay, it appears this person meets the criteria for MI and needs to be referred to the lead agency for further evaluation." On 3/13/2014 at 3:00 p.m., the Administrator provided a copy of the PASRR documentation completed by the county which had been faxed to the facility on 2/4/2014. However, the documentation that was provided did not have the level 2 screening attached. Interview with the Administrator indicated there was only the level 1 PASRR screening that had been completed . The level 2 screening was not provided.	F 285	F309 1.R39 care plan reviewed and updated to reflect non-pharmacological interventions for pain management , R46 has been discharged from the facility, R29 care plan reviewed and updated to reflect non-pharmacological interventions for pain management, R25 is deceased. 2. The DON/designee will complete an audit of all resident's pain assessment and development of care plans for pain. The DON/designee will complete an audit of all resident's pain management to ensure proper monitoring is being completed. The DON/designee will complete an audit on all resident in wheel chairs to ensure that proper positioning is being obtained. 3. The DON/Designee educated 03/25/14 all licensed nursing staff on facility policy and procedure on pain management to include assessment, care plan development and monitoring. The DON/designee will educate therapy department on wheel chair positioning document that will be completed upon admit, quarterly, annually and with significant change.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the necessary care and services were provided, based on assessment, development of a care plan, and monitoring related to pain management for 3 of 3 residents (R39, R46, R29) who were reviewed for pain and for 1 resident (R25) who was reviewed for positioning issues. Findings include:	F 309		

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FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(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 309	Continued From page 36 R39 was experiencing migraine headache pain and was not comprehensively assessed for pain to develop effective non pharmacological interventions to minimize pain, develop criteria to identify which as needed pain medication was to be used, document effectiveness of as necessary pain medication when administered. On 3/10/2014 at 6:30 p.m., R39 was looking for a nurse for pain medication. R39 was standing in the bedroom doorway with the call light on. The nurse shut the light off and told the resident she would get some or check on the medication. At 6:49 p.m., the resident was sitting in the bedroom in the chair and the resident indicated had a migraine and would rather not interview at that time but maybe tomorrow. At 7:00 p.m. a trained medical assistant (TMA)-C went down the hall with the medication cart but didn't stop to give R39 the requested pain medication for the migraine. At 7:10 p.m., TMA-C was interviewed and stated she was just told about the Tylenol request (40 minutes after the resident requested it), as she was on break, and she was going to ask R39 what the pain medication was for and she would check and see if the resident could have it. At 7:15 p.m., TMA-C came back and said the last time the resident had the Tylenol was at 1:45 p.m. and couldn't have it because received it every 6 hours. R39 was suppose to have oxygen on continuously but wouldn't do it. The TMA indicated the resident had to wait til 7:45 p.m. then could have the Tylenol ES 500 mg 2 tabs. The TMA stated they are trying to figure out why R39 was getting the migraines and requested pain medication every night at this time. Non pharmacological interventions were not offered or attempted.	F 309	309 Continued 4. The IDT/designee will monitor pain assessment and care plan development for pain quarterly using the care plan check list. The DON/designee will audit pain monitoring 3 times a week using the nursing management compliance document. The IDT/designee will monitor the completion of the wheel chair positioning document quarterly using the care plan check list. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 309	Continued From page 37 On 3/11/2014 at 8:00 a.m., R39 was observed sitting in the dining room and stated didn't take bath today and was short of breath. At 10:00 a.m., was observed up and about without oxygen on and then sitting in the lobby without oxygen on. At 11:50 a.m., was observed resting in bed with the lights off. At 1:20 p.m. was in bed resting and requesting a pain medication for headache. Non pharmacological interventions were not offered or attempted. On 3/12/2014 at 7:45 a.m., R39 up and sitting on edge of bed. At 1:20 p.m. in lobby, looking out the window, and stated feeling better today, and had Tylenol for a headache. At 3:20 p.m., R39 was in bed in darkened room resting. On 3/13/2014 at 8:00 a.m., R39 was out of room and at 9:00 a.m. was in room laying on the bed resting. At 11:46 a.m., the resident was up walking back from being outside and would not respond when spoken to. R39 was readmitted to the facility on 6/12/2013 with diagnosis which was listed in the medical diagnoses on the computer and included: chronic obstructive pulmonary disease, hepatitis C carrier, cardiac disease, esophageal reflux, nondependent cocaine abuse, drug-induced persisting dementia, and hypertension. A quarterly Minimum Data Set (MDS) dated 9/20/2013 identified the resident with moderate cognitive impairment, on a pain medication regime, received as necessary pain medications, and occasional pain affected activities and sleep. The intensity of the pain was rated as 8. A significant change MDS dated 2/7/2014, identified	F 309		

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F 309	Continued From page 38 the resident's cognitive status as moderate , no scheduled pain regime; as necessary pain medication offered; pain was present, almost constant, but didn't affect sleep or activities. The intensity of the pain was rated at 7. Physician notes dated 2/26/2014 were reviewed. The resident was identified with chronic tension type headache, and was on Depakote medication which was increased. A Neurology consult was recommended. (according to staff appointment is scheduled for 4/2/2014). 1/29/2014, the resident had chronic tension type headache and Ibuprofen every 6 hours was started and Depakote medication. No improvement with tramadol medication, minimal improvement with Tylenol, some improvement with morphine but daily use noted and with ongoing pain. The tramadol and morphine medications were discontinued. A pain assessment was completed on 7/12 2013 and 12/14/2013, but the data was not analyzed to come up with a summary of the pain issues, a plan identifying criteria to be used to determine which pain medication to be given and a plan for non-pharmacological interventions to be used. The resident was on 3, as necessary, pain medications. The medication sheets were reviewed for the following: For 12/2013 , R39 used Tylenol 1000 mg every bedtime; tramadol 50 mg every 6 hours as necessary for headache used (8x from 12/15-12/31) and Tylenol ES 500 mg every 6 hours as necessary for pain; for 1/2014, R39 used tramadol every 6 hours as necessary 26 times, Ibuprofen 400 mg every 6 hours as needed was used 3 x for headache, acetaminophen 1000 mg ES every 6 hours as needed used many	F 309		

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F 309	Continued From page 39 times, and morphine sulfate every hour as needed for moderate to severe pain was used many times. For 2/2014, R39 was on Imatrex 100 mg daily as necessary. The resident used it 15 times; used the ibuprofen medication many times and the acetaminophen 1000 mg ES many times. For 3/2014, the ibuprofen and acetaminophen were given several times as necessary. None of the as needed pain medications had criteria to identify when to use the medication and which of the many as needed medications to use for the resident's pain issues. Non pharmacological interventions or effectiveness of the as needed pain medication were not consistently documented. R39's care plan with print date of 2/13/2014 indicated the following: I have frequent intermittent headaches (chronic for me). Pain interferes with my ability to sleep at times, but doesn ' t interfere with my ability to do my own ADL's. My pain may be as bad as 7/10 on a pain scale. On 10-13 my provider ordered extensive testing (CD scan of sinus, neurology follow up, sleep study) and once ordered I refused all of this. Interventions: anticipate my need for pain relief and respond immediately. Evaluate the effectiveness of pain interventions, I am able to call for assistance. I prefer to have pain controlled by Topamax, melatonin, Tylenol and Ibuprofen. Use of narcotics is discouraged due to history of poly-substance abuse. monitor for side effects of pain med, prior to administering as necessary Tylenol, utilize non-pharmacological interventions such as ice for my head, relaxation techniques, document effectiveness.	F 309		

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F 309	Continued From page 40 On 3/13/2014 at 12:30 p.m., a trained medical assistant (TMA)-C was interviewed regarding use of as needed (prn) pain medications and documentation. TMA-C stated they are to document prn pain medication on back of MAR (medication administration record) and effectiveness or follow up, but not always completed. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the director of nursing (DON) was interviewed regarding pain assessments and use of as needed pain medications. She indicated the pain assessments were data collection but an analysis of the data was not completed to determine a plan. The use of prn (as necessary) pain medication should be documented on the MAR and follow up for effectiveness should be on the MAR. The staff were to use a pain management form in front of the MAR for each resident which included all the components. When checked, the MAR's did not have the pain management forms and the DON stated the staff were not doing it. There should be criteria related to which pain medication to use and when and she could not find the criteria. The DON also stated Non pharmacological interventions should be attempted prior to the medication administration. R46 lacked a comprehensive pain assessment, lacked a plan of care with non-pharmacological interventions for pain and lacked monitoring related to pain management. R46 was admitted to the facility 11/5/13. The care conference summary dated 11/25/13 indicated R46 had diagnoses that included alcohol induced persisting dementia, bipolar	F 309		

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F 309	Continued From page 41 disorder, and traumatic brain injury.	F 309		
	Physician orders signed 2/5/14 include ibuprofen 400 mg 1 tab by mouth three times daily as needed for pain, lidocaine 5% patch apply 1 patch and change daily on for 12-hours off for 12-hours, During an interview on 3/10/14 at 5:00 p.m. R46 stated he had pain but would not rate it. Stated he had numb feet. On 3/13/14 at 7:45 a.m. R46 was asked if he had pain. R46 stated he had ankle and foot numbness and that was where he wanted the lidocaine patch placed. R46 also stated he had back pain that he rated at a 7 out of 10. R46 stated he did not want the lidocaine patch placed on his back because it would not stay put. R46 was observed on all days of the survey 1/10/14 through 3/13/14 to transfer between surfaces, come to a stand, and walk without difficulty. The medication administration record was reviewed. As needed ibuprofen was given twice in January for complaints of back pain. The documentation of nursing observations did not document the intensity of the pain or if any non-pharmacological interventions had been attempted or if the medication had been effective. The as needed ibuprofen was given 6 times during February. Nursing observations were recorded four times indicating the medication was given for mouth pain but lacked intensity of the pain or if any non-pharmacological interventions had been attempted. Three of the four observations indicated relief. Ibuprofen was given once during the first 2 weeks of March. Nursing observations did not record the medication was administered.			

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F 309	Continued From page 42 The treatment administration record was reviewed. Pain was documented once per shift each day. The documentation indicated R46 did not experience pain The facility's pain assessment was completed on 2/5/14. The assessment indicated the resident experienced pain frequently that was rated at 4 on a scale of 00-10 (mild to severe intensity not addressed). The care area assessment (CAA) for pain dated 11/25/13 indicated the resident experienced pain at a scale rating of 6 and that the pain was almost constant. The analysis of findings indicated R46 had pain related to an ankle injury and was being managed by the physician. The CAA did not evaluate the frequency or intensity of pain, if there were any non-verbal indicators of pain, or any associated signs and symptoms related to the pain, any potential causal factor of pain, or the effectiveness of any pain management program. The plan of care printed 2/18/14 indicated a focus of pain medication with an intervention to administer medication as ordered. The plan of care did not identify where the pain was located and any non-pharmacological interventions to assist the resident to manage his pain. During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated with as needed pain medications nurses were to document pain location, intensity and effectiveness. DON stated she had just updated the care plans, but that all nurses were responsible for keeping the care plans current. R29 lacked a comprehensive pain assessment	F 309		

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F 309	Continued From page 43 and the development of a plan to manage the residents pain. R29 was observed on 03/11/2014 at 10:27 AM. R29 was slow to come to a sitting position in the bed. R29 ' s face appeared pained. R29 stated her back hurt. R29 also stated that her mouth burned because of decayed teeth. R29 was observed during noon lunch on 3/12/14 at 12:23 p.m. R29 was eating a regular diet independently and was spitting out what she called meat because her mouth burned. R29 was admitted to the facility in 2009. R29 had diagnoses listed on the medication administration record as osteoporosis, depression, dementia, and pain. R29 had a physician ' s order for Acetaminophen 325 mg tablet. 2 tabs by mouth 4 times daily for pain. No as needed medication (PRN) orders were found. The physician documentation of 1/15/14 noted the resident complained of back pain intermittently and had a diagnoses of lumbago. R29 had a physician ' s order dated 10/12/11 for Tylenol 325 mg tablets 2 tabs four times daily. The quarterly Minimum Data Set (MDS) dated 1/13/14 indicated R29 had a score for brief interview for mental status (BIMS) of 6 or severe cognitive impairment. The MDS identified R29 had pain and that no non-medication interventions were used. The frequency and intensity of the pain was not noted. The care area assessments (CAA) dated 8/5/13 was reviewed. The nutritional status CAA noted	F 309		

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F 309	Continued From page 44 "presumably the lack of concentration on the BIMS is a result of the oral pain." The pain status CAA noted : numeric rating scale for pain at a 6 and that resident indicated she had pain almost constantly. The CAA noted pain managed by Tylenol currently. The facility pain assessment dated 1/11/14 indicated denied pain, but stated she experienced pain occasionally. R29 rated her pain on a scale of 00-10 at a 3 or mild. The assessment indicated R29 would display facial expression when in pain and received scheduled Tylenol. The assessment did not indicate where the pain was located, what were potential causal factors of the pain and if an assessment for the cognitively impaired adult with pain had been conducted. The care plan printed 2/13/14 had a focus: reports moderate pain frequently related to arthritis of hips and back. Interventions: scheduled use of Tylenol. Administer medication as per MD orders and note the effectiveness. Give PRN meds for breakthrough [no PRN medications ordered] acknowledge presence of pains and discomfort. Document/report complaints and non-verbal signs of pain; The care plan lacked non-pharmacological interventions to assist R29 to manage her pain. Care plan problem focus: dental health problems as indicated by occasional oral pain. The interventions included: coordinate arrangements for dental care. Monitor/document/report to MD PRN symptoms of oral pain needing attention. The care plan lacked non-pharmacological interventions to assist R29 to manage her oral pain. The director of nursing (DON) was interviewed on 3/13/14 at 12:36 p.m. DON stated she was	F 309		

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F 309	Continued From page 45 aware of dental issues, but unaware of the resident ' s mouth burning. DON stated she was not sure the facility had a pain assessment for the cognitively impaired, but did know that pain had been an issue for R29. DON stated R29 complained of back pain last week. DON stated the care plan should be revised as necessary and that staff should follow the plan of care. R25 was not provided appropriate positioning when in the wheelchair or when in bed during meals. R25 was observed on 3/10/14 from 4:00 p.m. to 7:30 p.m. lying in bed with the head of the bed elevated. At 6:05 p.m. R25 received his meal and the head of the bed was elevated further. R25 was observed to have feet extended beyond the foot of the bed and was not positioned so that he sat in an upright position to eat safely. Licensed practical nurse (LPN)-I repositioned the resident higher in the bed by pulling the resident up without assist of 2 staff. On 3/13/14 at 8:25 a.m. R25 was observed lying in bed with head of bed elevated and a breakfast tray had been provided to the resident. Registered nurse (RN)-A entered the room to observe the resident's position and stated R25 was not positioned properly to eat the meal safely. RN-A left the room to find another staff person to assist with positioning the resident bed. The care area assessment for nutritional status dated 11/7/13 did not identify R25's safety with positioning and eating in bed. The care plan printed 2/13/14 identified a focus/problem of need assist with ADLs. Interventions included assist of	F 309		

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F 309	Continued From page 46 2 to boost up in bed dated 2/17/14, independent with eating, but did not direct the resident was to eat in bed and the safe positioning to eat in bed. On 3/11/14 at 9:30 a.m. R25 was observed sitting in the wheelchair. R25's back was not against the back of the wheelchair, R25's feet were on the floor, R25's was sitting forward in the chair so that his thighs were beyond the edge of the chair. The wheelchair cushion was beyond the front edge of the chair. When asked R25 stated he was not comfortable sitting in the chair. On 3/13/14 at 8:30 a.m. occupation therapist stated she had just provided R25 with a larger wheelchair and new cushion, but that she had not assessed R25 for wheelchair positioning. The care plan printed 2/13/14 identified a focus/problem of need staff assist with mobility. Interventions included use a wheelchair for mobility on the unit, will refuse to reposition almost every time. Explain why it has to be done and ask again kindly. If I am non-compliant it needs to be reported to nurse and if nurse cannot convince me to reposition, report to director of nursing. During an interview on 3/13/14 at 11:45 a.m. the director of nursing (DON) indicated staff were expected to follow the care plan. If the resident would refuse cares, staff should then re-approach the resident. DON stated she was unaware R29 had refused to be repositioned.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 47 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provision of grooming for 1 of 1 resident (R25) observed who required assistance with grooming. Findings include: R25 lacked personal grooming to remove facial hair. The quarterly Minimum Data Set (MDS) dated 1/24/14 identified diagnoses of diabetes, dementia, depression, psychotic disorder. The MDS indicated a total dependence of two staff for activities of daily living. R25 was observed throughout the survey of 3/10/14 through 3/13/14. On 3/11/14 at 9:30 a.m. R25 was noted to be unshaven. On 3/12/14 at 10:25 a.m. R25 was noted to be unshaven. On 3/13/14 at 9:30 a.m., R25 was again observed to be unshaven. R25 was interviewed on 3/11/14 at 8:38 a.m. R25 stated that staff would only shave him every other day and had not shaved him this day. The care plan printed 2/13/14 identified a focus of behavior problems. Interventions directed if resistive to cares staff should have a nurse	F 312	F312 1.R25 is deceased 2. Director of Nursing/designee will complete an audit to identify all residents who are dependent for grooming care. 3. Director of Nursing/designee educated 03/25/2014 all direct care staff on grooming dependent residents. 4. Director of Nursing/designee will complete weekly random audits to ensure staff is providing care for dependent residents. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 312	Continued From page 48 determine the option that is least detrimental; leave and re-approach later if continued to be resistive. The care plan identified a focus of resistive to care with interventions that directed if resist ADLs, reassure, leave and return 5-10 minutes later and try again. The care plan identified a focus needs assist with ADL's and interventions for grooming that directed staff need assist of 1 staff and encourage participation to comb own hair and brush teeth. The interventions did not provide staff with directions related to shaving. During an interview on 3/12/14 at 1:30 p.m. nursing assistant (NA)-J and trained medication aid (TMA)-E stated R25 was last shaved on Friday and that R25 did not always agree to be shaven. The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated she would expect shaving to be included in the care plan and for the care plan to be followed. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to be shaved.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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F 315	Continued From page 49 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive urinary incontinence assessment and provision of services for 2 of 3 (R25, R46) residents reviewed for incontinence. Findings include: R25 lacked a comprehensive incontinence assessment that included voiding patterns and lacked provision of services in accordance with the plan of care R25's quarterly Minimum Data Set (MDS) dated 1/24/14 was reviewed. The MDS identified diagnoses of dementia, depression, psychotic disorder. The MDS of 1/24/14 indicated R25 had total dependence on two staff for activities of daily living-including toileting care; did not have a toileting plan, and was always incontinent. The Urinary and Bowel Continence Risk Assessment checklist dated 2/13/14 indicated R25 had incontinence related to mental confusion and impaired mobility and therefore had functional incontinence. No analysis of data was documented. The Urinary Continence Intervention Guideline Tool dated 2/13/14 had a completed check list that identified R25 as having functional incontinence and recommended an assessment for pain, scheduling of a 3 day bladder elimination tracking to establish elimination pattern, and implementing prompted	F 315	F315 1.R25 is deceased, R46 has been discharged 2. Director of Nursing/designee will audit all residents' incontinence assessments to ensure they have an accurate assessment and provisions of care. 3. Director of Nursing/designee provided education 03/25/14 to nursing staff on how to complete assessments and create provisions of care. 4. Interdisciplinary Team will review resident assessments upon admission, quarterly, annually and with any significant change. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 315	Continued From page 50 voiding. The Tool did not have an analysis of data to determine why the recommendations were noted and what the outcome of the bladder elimination tracking was. The Urinary and Bowel Continence Risk Assessment and Urinary Continence Intervention Guideline Tool did not identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. A care plan was not developed based on assessments and evaluation. The care area assessment (CAA) dated 11/7/13 indicated R25 required extensive assistance for toileting and was always incontinent. The analysis of findings noted R25 was highly resistive to toileting. The CAA identified urinary urgency, diabetes, congestive heart failure and depression as contributing factors, but did not identify the type of incontinence or the voiding pattern/frequency. The CAA did not provide a plan of care based on the evaluation. The care plan printed 2/13/14 was reviewed. The care plan had a focus of "staff assist with toileting" and directed staff offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 p.m., to 7:30 p.m., R25 was observed to be lying on back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/11/14at 11:10 a.m., while visiting R25, a strong urine odor was detected. On 3/11/14 at 1:30 p.m. R25 was observed sitting in the wheelchair. A strong urine odor was detected and the crotch of R25's pants was observed to be	F 315		

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F 315	Continued From page 51 wet. On 3/12/14, R25 was observed from 10:25 a.m. to 1:30 p.m. R25 was not observed to be provided incontinence cares for 3 hours. Nursing assistant (NA)-J stated she had last repositioned and assisted R25 at 10:00 a.m. or a total of 3.5 hours. R25 was observed on 3/12/13 at 12:00 p.m. to 1:30 p.m. At 1:30 p.m. R25 received incontinence care (by observation 1.5 hours) NA-J stated she had last provided cares to R25 at 10:00 a.m. (a total of 3.5 hours) On 3/13/14 R25 was observed from 7:09 a.m. to 8:58 a.m. and no incontinence cares were provided. NA-C stated she had worked all night and had last changed and repositioned R25 at 5:30 a.m. (greater than 3.5 hours). During an interview on 3/12/13 at 1:30 p.m. NA-J stated two soaker pads were under the resident when in bed because he "wets a lot and this prevents soak through." The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated the urinary incontinence assessments were just being completed. The assessment was to include a 72 hour bowel and bladder diary to see if a pattern exists. The notations on the assessments should be included on the care plan. DON stated she would expect the care plan to be follow. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to receive incontinence cares. R46 lacked a comprehensive assessment and plan of care for incontinence. R46 was observed on 3/10/14 at 4:10 p.m. A	F 315		

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F 315	Continued From page 52 strong urine smell was noted. Licensed practical nurse (LPN)-I stated he also noticed the odor but was unsure if the odor was from R46 or another resident. LPN-I stated R46 did not like to get cleaned up. No staff interventions related to the incontinence or odor was observed. On 3/12/14 at 10:05 a.m. and at 10:25 a.m. R46 was observed sitting by the nursing station with 3 staff members present. A strong urine smell was noted. No staff interventions related to incontinence and odor were observed. On 3/13/14 at 7:10 a.m. a strong urine odor was detected. R46 was observed to be wearing the same clothing as the previous day. During an interview on 3/13/14 at 7:50 a.m. nursing assistant (NA)-C verified a strong urine odor, when near F46. NA-C stated R46 was to get a shower twice a week. NA-C was not observed to intervene. R46 was admitted 11/5/13. The Care Conference Summary dated 11/25/13 identified diagnoses of alcohol-induced persisting dementia, bipolar disorder, and traumatic brain injury. The admission Minimum Data Set (MDS) dated 11/12/13 and the quarterly MDS dated 1-12-14 both identified R46 as having a BIMS score (brief interview for mental status) of 13 or no cognitive impairment and to always be continent. The treatment record for November and December documented R46 was to get a shower every other day due to incontinence but documented the resident frequently refused or was not given the opportunity. The Care Conference Summary dated 11/25/13 noted resident "will uninate [sp] in pants and refuse to	F 315		

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F 315	Continued From page 53 change."	F 315		
	On 3/4/14 the facility completed Urinary and Bowel Continence Risk Assessment. The checklist identified impaired bladder emptying without documentation of a post void residual or that a physician exam had been completed, identified nocturia, and determined the resident demonstrated characteristics of overflow incontinence and characteristics of over active bladder/urge incontinence. The assessment did not identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. The assessments did not provide a plan of care based on the evaluation. No CAA was found or provided for urinary incontinence. Review of the care plan dated 2/18/14 did not reveal a plan/interventions to assist R46 to manage incontinence. The care plan identified the resident as independent with activities of daily living. The care plan also directed if the resident refused cares, the director of nursing was to be notified. The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated the urinary incontinence assessments were just being completed. The assessment was to include a 72 hour bowel and bladder diary to see if a pattern exists. DON stated she had not been notified of refusal of cares.			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 54 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 interview and document review, the facility failed to thoroughly investigate, comprehensively assess, effectively analyze and develop interventions to minimize risk of falls for 2 of 3 residents (R40, R70) reviewed for accidents. Findings include: R40's face sheet was reviewed and identified the resident was admitted to the facility on 1/11/2014 with diagnoses which included personal history of fall, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set, dated 1/17/2014, identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff for activities of daily living. The resident had a history of falls. Accident/incident reports for R40 were reviewed. On 2/15/2014, the resident was on floor next to the bed, had attempted to self-transfer and had no injury. Resident was identified as being confused , impaired decision making, weakness, gait imbalance and having impaired memory. The resident had been ambulating without assistance. The use of medications had not been	F 323	F323 1.R40 falls trend investigation completed, R70 has been discharged to ALF 2. Administrator/designee will audit fall in last 30 days to ensure a proper investigation has been completed 3. Administrator/designee educated 03/25/14 staff on the policy and procedure for completing fall investigation 4. Administrator/designee will take all falls to a weekly meeting with Interdisciplinary team for a fall review meeting to ensure falls have been properly investigated and followed through with intervention. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 323	Continued From page 55 assessed and there was no evidence of an investigation of the incident or interventions implemented. The resident had subsequent reports dated 2/21/2014 and 2/22/2014 which were not thoroughly investigated to include review for medications that could predispose the resident to falls. A fall risk assessment dated 1/11/2014 (on admission) was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. R40's care plan upon admission with initiated date of 1/14/2014 was reviewed. It did not identify falls risk and interventions to minimize the risk of falls. A written note dated 2/19/2014 (after the fall of 2/15/2014) identified the following: I am at risk for falls due to multiple risk factors, related to impaired balance, decreased endurance and unsteady gait. Interventions: OT/PT, call light within reach, bed and chair alarm, appropriate footwear, and anti- roll brakes on wheelchair. On 3/12/2014 at 10:30 a.m. and 2:15 p.m., the director of nursing (DON) was interviewed and verified the medications were not reviewed at time of the fall to determine possible cause. An incident report was completed for data but a thorough investigation had not been completed to identify causes and alternative interventions. The DON stated a fall trend investigation was not completed for the fall of 2/15/2014. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care	F 323		

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F 323	Continued From page 56 plan (on admission) should have addressed falls with interventions since the resident had a history of falls. R70 experienced an unwitnessed fall in his bedroom on 3/5/14, at 12:53 a.m., stating he had fallen in room, "bumped mouth on the bedside stand." Observation of slight bleeding from nose and redness to right cheek documented. No vital signs taken, sent to emergency room per request and R70 refused neuro checks. R70 experienced a second unwitnessed fall in his bedroom on 3/6/14, at 6:45 p.m.stating he fell in his room. BP 126/78 pulse 89 and denied hitting head. R70 experienced a third unwitnessed fall in his bedroom on 3/9/14 at 11:07 a.m. stating slipped in room and hit right cheek and shoulder on the floor. BP 139/89 pulse 78. R70 had a physician order for the whenever necessary (prn) medication Trazadone 50 mg (milligram) to be taken at bedtime for depression. According to the March medication sheet, R70 requested a prn dose of Trazadone on 3/4, 3/5, and 3/8. According to the Nursing 2014 Drug Handbook, Trazadone has a central nervous system adverse reactions of drowsiness, dizziness, syncope (fainting) and for cardiovascular there could be adverse reactions to blood pressure. R70's active diagnosis from the minimum Data Set (MDS) form dated 1/16/14, lists but is not limited to, hypertension, anxiety and muscle weakness. The MDS further indicated a history of falls with fracture 2-6 months prior to admission. R70's Brief Interview for Mental Status (BIMS)	F 323		

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F 323	Continued From page 57 dated 1/16/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact. When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified the three falls for R70 did not address any precipitating event to help prevent future falls which included the activity R70 experienced prior to the fall. Information was not available related to the precipitating factors associated with the resident, including depression/blood pressure/pain medication use and observation of anxiety level prior to the three falls. The undated document titled "Fall Prevention Program" directed the DON to complete a "Fall Trend Investigation Report" which was blank in the section to identify medication profiles and to list the prn medications the resident received in the past 24 hours.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		

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F 329	Continued From page 58 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 interview, and document review, the facility failed to develop parameters for use and failed to monitor the effectiveness of as needed psycho-active medications for 2 of 5 residents (R27, R40) reviewed for unnecessary medications. Findings include: R27 was on an anti-anxiety medication without parameters for use, documentation of effectiveness when used, and without use of non-pharmacological interventions; and was on multiple scheduled psychotropic medications without adequate monitoring . R27 was admitted to the facility 2/3/2014 with dx (from care plan) altered mental status, traumatic amputation of toes, sedative/hypnotic /anxiolytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal reflux, opioid type dependence abuse, dissociative identity disorder, drug-induced psychotic disorder with hallucinations, paranoid schizophrenia,	F 329	F329 1.R27 parameters has been implemented, care plan has been updated to reflect non-pharmacological interventions and target behaviors have been identified. R40 parameters has been implemented, care plan has been updated to reflect non-pharmacological interventions, sleep assessment also completed. 2. The DON/designee will audit all resident currently taking prophylactic antibiotic medication to ensure clinical rationale is present. The DON/designee will review all residents taking psycho-active medications to ensure parameters and effectiveness have been monitored. 3. The DON/designee educated 03/25/14 nursing staff on the importance of prophylactic antibiotic medications to have clinical rationale. The DON/designee will educate nursing staff on psychotropic medication and behavior monitoring policy and procedure.	

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F 329	Continued From page 59 A physician order dated 2/3/2014 identified R27 on Clonazepam 0.5 mg twice daily as needed for severe anxiety. The other scheduled psychoactive medications were Buspar, Elavil, Zyprexa, and Trilafon. Medication sheets dated 2/2014 and 3/2014 were reviewed. The resident used the as needed clonazepam (antianxiety medication) several times in both months. The scheduled other psychotropic medications were given as ordered. The target behaviors that were identified to be monitored included mood indicators, behavior indicators, hearing voices not there, seeing objects not there, agitation-not responding to direction, and pacing. These behaviors were documented on every shift daily. However, an analysis of the behaviors was not compiled of the data to identify effectiveness of the use of the as needed antianxiety medication and other multiple psychotropic medications (Buspar, Zyprexa, Elavil, Trilafon). R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The use of the as necessary and scheduled psychotropic medications with interventions was not addressed. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of prn antianxiety medication. DON stated staff should be documenting in the MAR and follow up for effectiveness. They are to attempt non pharmacological interventions prior to the prn use. The documentation was not evident in the MAR or record and the DON verified that.	F 329	F329 Continued 4. The DON/designee will audit all new prophylactic antibiotic medications 3 times a week using the nursing management compliance rounds to ensure clinical rationale is present. The DON/designee will monitor psycho-active medications 3 times per week to ensure parameters and effectiveness are being monitored using the nursing management compliance rounds. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 329	Continued From page 60 On 3/13/2014 at 12:50 p.m., and 3:00 p.m., the DON was interviewed regarding a summary/analysis of the behavioral data to identify effectiveness of the scheduled medication and use of the as needed antianxiety medication. She indicated no analysis was done of the behavioral data. No criteria for the use of the as needed medication was provided. R40 used as needed antianxiety medication for sleep and anxiety without criteria for use, monitoring of effectiveness and lack of use of non-pharmacological interventions prior to administration. A Discharge summary from the hospital dated 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed. Admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder,paralysis agitans, compression of brain, parkinson's disease, hx of alcohol use, intracerebral hemmorrhage, obstructive hydrocephalus, insomnia. (on MD notes 1/29/2014) A physician order dated 1/16/2014 identified Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety; and Lorazepam 0.5 mg (4 tabs of 2 mg.) by mouth at bedtime as needed for sleep. R40's following medication sheets were reviewed: Lorazepam (antianxiety medication) was used as necessary for sleep and/or anxiety: 1/14--9 times; 2/14- was used 23 times and in 3/14-it	F 329		

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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 329	Continued From page 61 was used 8 times. A sleep evaluation dated 1/13/2014 was reviewed. It identified the resident had difficulty staying asleep; related to pain; did not have a history of taking sleep medications routinely prior to bedtime. An average length of nap was 1-2 hours.. R40 had neurological deficits (stroke, Parkinson's disease, seizure disorder). No environmental factors contributing to resident sleeping difficulties was identified. The assessment was a collection of data but did not contain a summary or analysis of the data to determine a plan. R40's care plan with initiated date of 1/14/2014 and print out date of 2/20/2014 was reviewed. It did not address R40's sleep issues or use of as needed antianxiety medications with interventions. On 3/13/2014 at 11:45 a.m., a trained medical assistant (TMA)-C was interviewed regarding use of the antianxiety medication. TMA-C indicated she did not give the medication during the day and indicated R40 was given the medication at night for sleep. The resident got anxious but rarely used it throughout the day because the resident was up and about. The TMA did not know if there was criteria to use prior to giving the medication. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the DON was interviewed regarding criteria for use of antianxiety medication. DON stated they should be using non pharmacological interventions prior	F 329		

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F 329	Continued From page 62 to administering the medication and should be following up also for effectiveness. The DON indicated she just did an education on that on 2/17/2014. She also checked for R40 re: sleep monitoring and indicated it was not being done. DON verified they did not analyze the sleep assessment data to come up with a plan.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the provision of thickened liquids as ordered by the physician for 1 of 1 resident (R29) reviewed with thickened liquids. Findings include: R29 was not provided thickened liquids during meals. R29 was admitted to the facility in 2011 and had diagnoses that included diabetes, Alzheimer's, depression, according to the physician orders signed 1/31/14. R29 was observed on 3/12/14 at 12:20 p.m. eating lunch independently. R29 had been served a regular diet with regular liquids. On the tray were a glass of water, a glass of juice and a cup of tea. At 12:30 p.m. trained medication aide (TMA)-E placed a spoon into each glass and	F 367	F367 1.R29 orders for thickened fluids were addressed with PCP 2. Audit completed of all resident dietary orders by DON/designee to ensure all diet orders are accurate 3. Staff educated on 03/25/14 where to find resident diet orders by DON/Designee 4. IDT will review dietary orders on admission, quarterly, annually and with any significant change. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 367	Continued From page 63 stated the fluids were of thin consistency. TMA-E stated she had not observed R29 to cough while eating. R29 was observed during the morning meal on 3/13/14 at 8:15 a.m. R29 was served a regular diet and thin liquids (orange juice, prune juice, milk, water.) TMA-F stated the liquids were thin. Nursing assistant (NA)-C stated R29 had never had thickened liquids since NA-C had started working in the facility a year ago. TMA-F verified on the medication administration record R29's liquids were to be nectar thick and proceeded to use thickener. The physician orders dated 10/26/13, 11/27/13, 12/31/13, 2/5/14, 3/12/14 all ordered Liberal ADA/mechanical soft with nectar thick liquids. Ok for thin milk on cereal. On 2/12/13 the speech therapist recommended nectar thick liquids. The tray card on the meal tray identified the resident was to receive nectar thick liquids. The care area assessment (CAA) dated 8/5/13 did not identify type of diet R29 was to receive. The quarterly Minimum Data Set (MDS) dated 1/13/14 indicated R29 was able to eat with limited assist of one staff, had no swallowing disorder, was on a therapeutic diet, and did not have speech therapy. The dietitian notes of 3/12/14 noted R29 was to receive a liberal ADA diet with nectar thick liquids. Review of the care plan identified a problem initiated 6/7/11 and revised on 10/11/13 that stated R29 had a swallowing problem related to difficulty with regular food. Coughing or choking during meals or swallowing medication. Interventions dated 4/20/13 indicated diet to be followed as prescribed: liberal diabetic, mechanical soft textures with thin liquids.	F 367		

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F 367	Continued From page 64 During an interview on 3/13/14 at 8:33 a.m. the administrator stated she was aware the liquids were to be thickened and had not been. During an interview on 3/13/14 at 1:00 p.m. cook-C stated she was unaware of the need for the thickened liquid until today when she received a note from licensed practical nurse (LPN)-J that the diet order was changed to thin liquids. LPN-J was interviewed 3/14/14 at 1:10 p.m. and stated that since last August when LPN-J started working in the facility, R29 had not received thickened liquids.	F 367		
F 371 SS=E	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 ensure a sanitary environment in the ktichen was maintained for storage and preparation of food. This had the potential to affect 41 of 43 residents in the facility who may have eaten foods prepared from this kitchen.	F 371	F371 1.Education of Dietary staff to encompass sanitation of kitchen by Administrator 04/17/2014 2. Audit completed of Dietary Department to determine if there is any sanitation concerns identified by Dietary Consultant. 3. Dietary staff educated by dietician on maintaining a sanitary dietary department. 4. Dietary Manager will complete weekly audits of dietary department to be reviewed with Administrator weekly. 5.If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 371	Continued From page 65 Findings include:	F 371		
	On 3/10/2014 at 1:45 p.m., an initial tour of the kitchen was completed with Cook-A and Cook-B. The following was observed during the tour: The blender and Robot Coupe Blixer 3, located on a soiled metal stand, were coated with debri. All three shelves of the cart on wheels, which had food equipment stored, were soiled with food debri. A hand mixer was coated with food debri. The cupboards which had the spices stored were observed to have food debri and also inside the drawers that had food utensils stored. Inside the refrigerator was a tray of barbecue sauce and mayonaise in small individual plastic containers that were covered with a clear wrap. However, they were dated 3/2/14. The cook indicated leftover foods are used within 3 days. A staff coat and staff purse were stored on the shelving that contained several loaves of bread. On 3/12/2014 at 12:30 p.m., a case and book were laying on the same shelf as the bread racks. Cook B verified it was employee items and shouldn't be there. The three compartment steam table was full of very thick limed encrusted material. Two large double boilers were observed. The bottoms were encrusted with thick lime. The tops of the double boilers were pitted and dented. Cook-A said they were used to make soups and noodles. A very large skillet was observed to be pitted and blackened. The cook indicated she asked for a new one and was given a skillet from a sister facility to use for making eggs, and other breakfast food.			

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F 371	Continued From page 66 The ice machine had a layer of food debris along the top edge of the lid where it opened. There were resident use water cups stored in a closed cart located next to the ice machine that were cracked and discolored on the inside of the cups. Cook-A indicated she thought night staff ran the cups through the dishwasher nightly. On 3/12/2014 at 11:45 a.m. observation of the kitchen was made: A staff case and personal reading book were laying on the same shelf as the bread loaves. Cook B verified the employees items shouldn't be there. The weekly schedule for cleaning was reviewed with Cook-B for the month of March 2014. Several tasks were not checked as being done and Cook-B said they sometimes forget to mark it off and there are times they just don't have time to get the cleaning done because there is so much work to do. On 3/10/2014 at 1:45 p.m., Cook A verified the concerns noted in the kitchen. On 3/12/2014 at 12:30 p.m., Cook B verified the concerns noted in the kitchen. During the environmental tour on 3/13/14 at 8:30 a.m., with the director of maintenance and director of housekeeping the resident refrigerator located in the dining room/day room on the secured unit was checked. The upright refrigerator freezer compartment had melted ice cream and other food debri spilled on the walls and floor of the freezer. The refrigerator compartment had several resident labeled	F 371		

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F 371	Continued From page 67 sandwiches that were not fully sealed and the bread crusts were dry to touch. The two pull out drawers located at the bottom of the refrigerator compartment were soiled with food spills and there was visible black/brown debris the housekeeping supervisor thought was mold. Interview with the maintanance director, it was learned the refrigerator is to be cleaned by the dietary staff.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide rehabilitative services as necessary for 1 of 1 resident (R46) reviewed. Findings include: R46 lacked a referral for rehabilitation services. R46 was admitted on 11/5/13 from an acute care hospital to the facility's locked dementia unit. R46's diagnoses listed on the preadmission screening dated 11/5/13 at Karsakoff dementia	F 406	F406 1.R46 was discharged from facility 2. SSD educated 04/17/2014 regarding residents admitted with significant alcohol/drug abuse history, that assessments need to be completed and referrals made as appropriate. 3. Admin/SSD will complete reviews of admissions regarding potential need for in-pt/out-pt rehab services 4. Daily meeting will encompass a review of potential admissions and needs including discharge planning. 5. If any issues are identified it will be addressed through the facility's QA meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 406	Continued From page 68 (alcohol induced dementia) and bipolar disease. The care plan printed 2/18/14 identified R46's diagnoses as alcohol induced dementia, bipolar disorder, alcohol dependence, drunkenness, acute alcoholic hepatitis. The Admission Minimum Data Set (MDS) dated 11/12/13 and the quarterly MDS dated 1/12/14 indicated R46 had a brief interview for mental status (BIMS) score of 13/15 or no cognitive impairment, displayed no behaviors, was independent with activities of independent living. During an interview on 3/10/14 at 5:13 p.m. R46 stated was admitted with a diagnosis of alcohol abuse and had not been involved in a treatment program. R46 stated he had investigated outpatient services, found some available in this community, but had not been provided access to them. R46 stated he would be willing to do outpatient or inpatient treatment. The care conference summary dated 11/25/13 noted, "Resident would like to be in a treatment facility or a facility where people are younger." The care plan printed 2/18/14 was reviewed. The resident's history with alcohol and request for treatment was not noted. During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she thought social services was working on the treatment issues. The social service designee (SSD) was interviewed on 3/13/14 at 12:57 p.m. SSD stated R46 had discussed with her the request of treatment as outpatient or inpatient. SSD stated she had contacted the guardian. SSD stated the	F 406		

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F 406	Continued From page 69 guardian did not want R46 to go to treatment because guardian was afraid R46 would not be able to return to the nursing home. SSD stated she had also discussed treatment with the county case manager and that he had said the facility needed to get the guardian on board. SSD stated the management team stated the facility would not hold the bed for return following the 90-day inpatient treatment program so SSD did not know if a readmission bed would be available. SSD stated she had not investigated further for outpatient treatment. SSD stated she was unable to find any social services documentation from previous social worker related to treatment programs.	F 406		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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	F 441		

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F 441	Continued From page 70 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during dressing change for 1of 2 residents (R45) with a gastric tube dressing and tube feeding, failed to ensure isolation precautions were adhered to for 1 of 1 residents (R48) with isolation precautions and failed to assure 1 of 1 residents (R10)Nebulizer equipment was sanitized between use. Findings include: R45 had a gastric feeding tube and during dressing change, infection control practices were not implemented to prevent spread of infection. R45 was readmitted on 12/26/2013 with diagnoses (listed from the care plan) that included: encephalopathy, dysphagia, history of	F 441	F441 1.Nursing staff educated 03/25/2014 by DON regarding infection control practices related to dressing changes, neb treatments, tube feedings and isolation precautions. 2. Nursing staff educated by DON/Designee 03/25/2014 related to dressing changes, neb treatment, tube feedings, and isolation precautions. 3. Infection Control audits will be completed weekly by DON/Designee to ensure the facility is preventing the spread of infection. 4. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 5. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 441	Continued From page 71 traumatic brain injury, post traumatic seizures, dementia with behavioral disturbances, episodic mood disorder, schizophrenia, and CVA (stroke). During observations, on 3/11/2014 at 9:20 a.m., LPN-C went into R45's room to do a dressing change around the gastric tube. LPN-C gloved and removed the dressing which had a tiny bit of blood tinged drainage on it. Without changing gloves, the LPN opened drawers and touched packaged supplies, the resident's chair, door handles to the closet, a blood pressure cuff, bag containing oral toothettes, and a mat which was leaning against the closet. Keeping the same gloves on, the LPN took water from a pitcher and use a Q-tip to clean around the gastric tube stoma area. Slight pinkish drainage was noted on the Q-tip. LPN-C then touched the medication and feeding syringe and tube extension. LPN-C snapped the extension on the gastric tube and checked for patency using a stethoscope. When attempting to administer water, the water did not go in. LPN-C had to use the stethoscope again to listen for patency. At that point, the LPN-C was wearing the same soiled gloves and touched the resident's skin, the stethoscope and the tubing. She disconnected the extension tube and took it into the bathroom to rinse it out. The LPN -C did not change the soiled gloves and continued to reapply the extension tube to the gastric tube. Without changing the soiled gloves, the LPN-C continued to administer water and medication through the tube using the same syringe. After LPN-C was finished with the medication task, she did not have gauze to put around the stoma area. She removed the soiled gloves and went out to the medication cart to find the gauze. The LPN gloved and put the gauze around the stoma.	F 441		

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F 441	Continued From page 72 On 3/12/2014 at 11:00 a.m., the director of nursing (DON) was interviewed regarding lack of infection control procedures used with R45's dressing change to the gastric tube site. The DON stated the nurse's should be following standard precautions and also the facility policy for dressing changes that are not sterile. A policy was requested and provided by the facility. A policy for Dressing-Non-sterile Treatment revised 6/2013 was reviewed. It identified: "6. Place supplies on clean field. 7. Wash hands. 8. Apply clean gloves. 11. Remove soiled dressing and dispose of in bag. Remove gloves. Wash hands. 12. Apply clean gloves. 13. Clean wound per physician orders. Cleanse wound from center to outer boarders using a circular motion (area of most contamination to area of least). Ensure you do not touch other skin surfaces, furniture, bedding, etc., and return to wound bed as this will contaminate the wound bed. 14. Dispose of cleaning supplies in bag. 15. Remove gloves and wash hands. 16. Apply clean gloves. 17. Apply dressing as ordered." R48 had respiratory methicillin resistant staph aureous (MRSA) with a tracheostomy and infection control precautions were not consistently implemented. A physician note dated 3/5/2014 identified history of present illness: Respiratory: Patient with chronic tracheostomy and with increased cough shortness of breath and sputum culture showed MRSA and Pseudomonas and started on IV antibiotics. Treatment for bronchopneumonia:	F 441		

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F 441	Continued From page 73 possible pneumonia with sputum with pseudomonas and MRSA. On 3/10/2014 at 5:20 p.m. R48's room door was closed. A note to check at nurse's station was on the wall at the doorway. A plastic cupboard at the doorway contained gowns, gloves, masks, red bags, and a blood pressure cuff and thermometer. On 3/11/2014 at 8:00 a.m. R48 was observed ambulating in the hall with a walker and had a mask over a trach site and then stood at the medication cart waiting for medications. At 9:00 a.m., R48 was observed to come out of the room with the mask off the trach site. A licensed practical nurse (LPN)-C puts a mask over the trach site and tells the resident it needed to be on because of an infection the resident had. LPN-C stated the resident was on precautions related to respiratory methicillin resistant staph aureos (mrsa). LPN-C gloved and put a mask on and stated she didn't gown because the resident didn't spit. She wore a mask because of droplets in the air and coughing from the trach and R48 was not good about leaving a mask on. The LPN went into the resident room and assisted the resident out of the bathroom. The resident took the mask off the trach and sat on the edge of the bed. At 9:47 a.m., R48 came out of the room with a mask over the trach and stands by the medication cart. The LPN touched the resident's walker to redirect the resident away from the cart and then without cleansing her hands continued to set up medications. At 10:00 a.m., R48 removed the mask and threw it on top of a waste basket on the cart but it just laid on top of the basket. LPN-C applied a new mask and	F 441		

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	245097	A. BUILDING _____ B. WING _____	C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(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 74 continued to set up the medication without washing her hands. At 2:05 p.., R48 came ambulating out from room to nurse's desk without a mask over the trach. The resident's room is the second door down the hall and so the resident walks a distance to get to the nurse's station. The nurse saw the resident and got a mask. On 3/11/2014 at 10:00 a.m., R48 walked into the nursing station and stood over NA-K who tried to redirect the resident back to his room since the tracheostomy was not covered. On 3/12/2014 at 7:45 a.m., R48 was observed up with walker at nurse's desk, however, had a mask on trach site. At 9:45 a.m., R48 was observed ambulating in the hallway with walker and no mask on. LPN-C tried to redirect the resident, touched the walker, and continued to set up medication, without washing hands, while the resident stood there. LPN-C indicated she didn't wear a gown in the room but just a mask and gloves because the resident didn't cough or spray and she didn't even during suctioning because everything goes up the tube and there is no spray there. At 10:00 a.m., LPN-C entered the room with mask and gloves on. There were no gowns in the container outside the room. The resident is already laying in bed. The LPN pulled on the incontinent cloth pad under the resident, moved the resident ' s feet, touched the linens and then the resident's forehead. With her gloves still on, she raised the bed with the controls. Without changing gloves, LPN-C removed the mask over the resident's trach, touched the dressing around the trach, and then removed the inner cannula and disposed of it in the wastebasket. Then removed the soiled gloves (had mucous on them)	F 441		

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F 441	Continued From page 75 and regloved. The LPN Opened up the new package of cannula and put it in the trach site. With the gloves still on, the LPN administered the neb medication into the neb mask and extension and started it up and placed it on the resident over the trach. She got out a new feeding syringe and dated it, poured water into a pitcher, touched the resident clothing and dressing to the feeding tube. Went into her pocket for something and then removed the tip of the syringe and put an extension on the feeding tube. She put the syringe in the tubing with air in it and takes a stethoscope to check for placement. The LPN retrieved 2 cans of feeding formula out of the box in the room, while holding the feeding syringe without a cap on it next to her clothing. Without changing gloves, or the feeding syringe, the LPN puts the syringe into the extension tube to the tube feeding and gives the resident the medications and water flushes. After finishing , the LPN then unhooked the extention tube and recapped the syringe tube. Without changing her gloves, she touched around the stoma skin site of the tube feeding and then readjusted the nebulizer mask and parts, then put on a clean dressing to the tube site. The bathroom did not have any soap in the dispenser. But the LPN indicated she had sanitizer on her medication cart. When checked, the sanitizer was not on the cart and another staff had to retrieve some. At 3:15 p.m., R48 had been out at nurse's desk several times, however the resident did have mask on over the trach site. On 3/12/2014 at 10:30 a.m., LPN-C verified she did not change her gloves appropriately throughout the procedures for R48. On 3/12/2014 at 12:45 p.m., LPN-J went into	F 441		

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F 441	Continued From page 76 R48's room without putting on a mask and gloves or gown. She laid a cloth chux on the resident's bed and straightened it out touching linens. The resident had a mask over the trach but was noted to cough. When the LPN-J went into the bathroom to wash her hands she noted there was no soap in the dispenser. She went to the soiled utility room to wash her hands. It was 2 doors down from the resident's room. LPN-J told the housekeeper the resident's bathroom needed soap and the housekeeper went in and filled the dispenser. On 3/12/2014 at 12:49 p.m., a nurse aide (NA)/medical records (MR) (NA)-K/(MR)-K walked into R48's room without a mask, or gloves or gown on. The aide directed the resident into the room and touched the walker and the resident on the back. The resident wanted assistance to get into bed. The aide walked out without washing her hands. NA-F put her gloves on and mask and went in to assist the resident into bed. NA-F was interviewed about the resident and use of a mask over the trach area. She indicated the nurse aides put a mask over the trach when they do cares on the resident . If they see R48 come out of the room, they redirect the resident back to the room and encourage the resident to put a mask on or they do it for the resident. The resident was independent with toileting and washing own hands. On 3/13/2014 at 6:45 a.m. , LPN-B was observed in R48's room suctioning the resident. The resident was coughing. LPN-B did not wear a mask but had gloves on. No gowns were available in the cabinet outside the resident's door. At 8:30 a.m., R48 came out to nurse's desk without a mask on and 2 staff (NA-K, LPN-J)	F 441		

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F 441	Continued From page 77 walk by the resident for several minutes before redirecting the resident to get a mask on. On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. R48 was placed on precautions because the resident had a positive culture for MRSA respiratory. Interviewed the DON on observations of poor handwashing and glove exchange, lack of soap in the bathroom, lack of gowns in the cupboard and also discussed observations of resident leaving room without a mask and sometimes being directed and other times not. The DON indicated the staff should be following the precautions because the resident was positive for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precaution sign was placed at the doorway of the resident's room. On 3/13/2013 at 2:00 p.m., R48 walked into the nursing station and stood over RN-A for several minutes until RN-A was able to direct R48 back to his room as the tracheostomy was not covered. On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was interviewed. and verified R48 had a problem coming out to the desk area and in the hallways without keeping the trach area covered as directed by facility protocol. On 3/13/2014 at 1:30 p.m., the DON was again interviewed regarding infection control	F 441		

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F 441	Continued From page 78 procedures. She stated "[R48], we are unable to keep him in isolation so he is in what we call precaution, but he does not follow through with that either. We are constantly taking him to his room and reapplying the masks to cover the trach (tracheostomy)." NEBULIZER EQUIPMENT WAS NOT SANITIZED BETWEEN USE: R10 s nebulizer system was observed on 3/12/14 at 10:15 a.m. to be located on his bed side stand. The nebulizer cup and tubing was attached to the machine. The nebulizer cup where the medication is placed was coated with moisture drops on the inside of the cup. Licensed practical nurse (LPN)-B was interviewed on 3/12/14 at 10:15 a.m. and said that she had set up and given R10 his nebulizer medication treatment at 8:00 a.m. However, LPN-B had not cleaned the equipment following the inhalation treatment to prevent bacterial and/or fungus growth as outlined in the facility policy. Again on 3/13/14 at 1/17 p.m. R10's nebulizer was noted to be fully connected and this time there was a white film coating the entire inside of the nebulizer cup. On asking R10 about the use and care of the nebulizer equipment at this time R10 said, "They [referring to facility staff] don't ever clean it." R10 said that he had used the nebulizer equipment earlier in the day and no one has touched it since then. On 3/13/14 at 2:00 p.m. trained medication assistant (TMA)-A was asked about the use and	F 441		

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F 441	Continued From page 79 cleaning of R10's nebulizer equipment following the inhalation treatment. TMA-A said that the equipment is to be taken apart and the cup is to be rinsed in water and the equipment is to air dry. However, this had not been done following R10's inhalation treatment on 3/12/14 8:00 a.m. dose nor on 3/13/14 after 8:00 a.m. dose. The director of nursing was made aware of lack of following the facility policy on the care of the nebulizer equipment on 3/13/14 at 2:47 p.m. and she was also asked for the policy in regards to the nebulizer inhalation procedure. Facility policy Desert Health Group Small Volume Nebulizer Procedures, revised date 06/2013 read, "11. Administer therapy until the medication is depleted (about 10-15 minutes)." and "13. Disassemble device and rinse the mouthpiece and nebulizer cup with water and dry. Store unit per facility policy. Dispose of equipment per facility policy."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to keep kitchen equipment and the kitchen environment clean and sanitary, also failed to keep the physical environment free from foul odors. This had the potential to affect 41 of 43	F 465		

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F 465	Continued From page 80 residents residing in the facility and had the potential to staff and the public. Finding include: During the kitchen tour with Cook-A and Cook-B on 3/10/14 at 1:45 p.m. the following was observed: Upright freezers and refrigerators located in the kitchen had a thick layer of dust covering the grill and when the grill was moved the dust covered the entire top of the pieced of equipment. The ice machine located in the dining room was observed to have the grill covered with a thick coat of dust/debris and the reusable filter was coated with white powder type debris. The floor in the kitchen had multiple food debris scattered around the perimeter of the room. The electrical cords and water tubing connected to the appliances including the coffee maker was coated with a thick layer of dust/debris. The metal emergency pull ring located near the coffee machine had long strands of dust/debris. During the environmental tour on 3/13/14 at 8:30 a.m. accompanied by the director of maintenance and lead housekeeper. The following was observed: The bathroom in room 113 had a strong urine odor present and the toilet had been flushed and the odor continued to be present. The housekeeper said it sometimes smells and they do clean in the bathroom. However, the urine smell continues to be present. The 300 wing was observed to have resident use	F 465	F465 1. All staff has been educated 03/25/2014 by DON related to a clean environment, clean equipment, utilizing a work order to identify areas in need of repair. 2. Environmental audits will be completed by Administrator/ Designee to ensure a clean safe environment. 3. Staff educated 03/25/14 on using a work order to identify areas in need of repair and cleaning. Staff educated 03/25/14 on maintain a clear hall way. 4. Weekly environmental audits will be completed by Administrator/Designee to ensure a clean safe environment. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14

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F 465	Continued From page 81 equipment including wheel chair, weight chair, resident lifts lined down the west side of the hallway. Also the medication cart is placed on the west side of the hallway. There were two residents who met each other going in the opposite directions and one of them had to move into an open door way to allow the other resident pass them by. With the west side of the hallway used to store resident equipment the residents who are ambulatory do not have free access to the hand rails on the west side to the hallway. On asking the maintenance director and housekeeper it was learned that they have to use the west side of the 300 wing to store resident equipment because there is no storage room in the area to keep them. It was also learned from the maintenance director and housekeeper that this practice of keeping resident equipment stored on the west hallway has been practiced for a long time.	F 465		

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	245097	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/13/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF A ACCEPTABLE POC, AN ON-SITE REVISIT 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 Fire Marshal Division. At the time of this survey, Faribault Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok FS 4-21-14 RECEIVED APR 17 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DOC: 4-22-14
EXIT: 3-13-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Sellers	Administrator	04/17/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 By email to: Marian.Whitney@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. Faribault Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1992, addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 43 beds at the time of the survey.	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:30 AM and 01:30 PM on 03/13/2014, based on review of available documentation it was reveled that fire drills were not varied throughout the shift during the evening shift. 3 of 4 drills were conducted between 3:15 PM and 4:50 PM. The fourth drill was conducted at 9:05 PM. This deficient practice was verified facility Maintenance Director (CB).	K 050	K050 1. Fire drills will be conducted at an increased varied time to ensure all shifts and are addressed, also making sure the drills are completed at times that are not convenient for staff 2. Monitoring will be completed by Administrator with review of the times of the drills monthly. 3. Education completed with Maintenance Director 04/07/2014 4. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 5. The facility will be in substantial compliance by 04/22/2014	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire	K 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 154	Continued From page 3 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 review and interview, the facility failed to develop a separate written policy containing procedures to be followed in the event the automatic fire sprinkler system is out-of-service for more than four hours in a 24-hour period. This deficient practice could affect all residents, staff and visitors in the event of a fire. 200 LSC Sec 9.7.6.1 Findings include: On facility tour between 09:30 AM and 01:30 PM on 03/13/2014, it was discovered during policy review and interview with the Maintenance Director (CB), that the facility has not developed a separate policy and procedures for an out-of-service fire sprinkler system.	K 154	K154 1. Separate policies have been developed and implemented to reflect the automatic fire sprinkler system and the fire protection systems if ever out of service. 2. Monitoring will be completed by Administrator 3. Education completed with Maintenance Director 04/07/2014 4. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 5. The facility will be in substantial compliance by 04/22/2014	

MINNESOTA
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7475

April 8, 2014

Ms. Shelley Solberg, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5097024

Dear Ms. Solberg:

The above facility was surveyed on March 10, 2014 through March 13, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5097061 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 me.

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.

Please feel free to contact me with questions about this letter.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00989	A. BUILDING: _____ B. WING LICENSE AND CERTIFICATION	C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(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: A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. " An investigation of complaint H5097061 was completed. The complaint was not substantiated.	2 000 4/22/14 SER	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.	

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2 000	Continued From page 1	2 000	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. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 380	MN Rule 4658.0200 Subp. 2 Policies Concerning Residents; Telephones Subp. 2. Telephones. A nursing home must provide at least one non-coin-operated telephone which is accessible to residents at all times in case of emergency. A resident must have access to a telephone at a convenient location within the building for personal use. A nursing home may charge the resident for actual long distance charges that the resident incurs. This MN Requirement is not met as evidenced by:	2 380		

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2 380	Continued From page 2 Based on observation, interview and document review the facility failed to ensure privacy during telephone usage for 1 of 1 (R46) residents observed using the telephone. Findings include: R46 was not provided privacy during phone calls. During an interview on 3/10/14 at 5:11 p.m. R46 stated not allowed to use the portable telephone and felt rights were taken away. " Make me sit here as a good boy " . R46 was observed on 3/12/14 at 10:05 a.m. sitting in the hallway using the telephone in the nursing station. Three staff and three residents were within hearing distance. On 3/12/14 at 10:19 a.m. R46 stated the telephone call was to be private because it was to a health care provider. R46 stated did have a cell phone, but that the use of the cell phone cost money. On 3/12/14 between 1:00 p.m. and 3:00 p.m. R3 was observed to use the telephone at the nursing station four times. When asked, resident stated these phone calls were not private. Review of documents indicated R46 was admitted to the memory care unit on 11/5/13. The admission Minimum Data Set (MDS) dated 11/5/13 indicated the resident had a brief interview of mental status score (BIMS) of 13 or no cognitive impairment, displayed no behaviors, and was independent with all activities of daily living. A sign was posted outside the memory care unit. The sign stated, " Resident phone is not allowed on Memory Lane until further notice. Thank you."	2 380		

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2 380	Continued From page 3 During an interview on 3/13/14 at 12:10 p.m., the director of nursing verified no portable telephone was available in the memory care unit. DON stated it was her understanding that R46 would use the telephone for hours and not allow other residents to use the phone. DON verified the incident of being at the nursing station with staff in area was a privacy issue, but added the resident could use personal cell phone. During an interview with the social service designee (SSD) on 3/13/14 at 1:00 p.m., SSD verified the portable phone was not to be used in the memory care unit. SSD stated R46 was told that the nursing station phone was available for use. SSD stated R46's guardian did not want R46 to have access to the portable phone to call her. SSD stated the phone at the nursing station was not private. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies are updated and that staff are trained to assure residents have access to a telephone and have privacy during telephone usage TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 380		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A	2 540		

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2 540	Continued From page 4 nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to assess 1 of 1 residents (R46) for appropriateness of placement in the dementia/memory care unit at the time of admission. Findings include: R46 lacked an assessment for the appropriateness of placement on the locked dementia unit.	2 540		

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2 540	Continued From page 5 R46 was admitted to the locked dementia unit on 11/5/14 directly from an acute care hospital. The initial Preadmission Screening (PAS) dated 11/5/13 indicated R46 needed behavior management or instruction, was resistant to redirection, and had a history of homelessness.. During an interview on 3/10/14 at 5:06 p.m. R46 stated he was only 50 and felt this was not an appropriate placement. The care conference summary dated 11/25/13 indicated R46 had stated he did not want to be " locked up " Review of the admission Minimum Data Set (MDS) dated 11/12/13 noted R46 had a BIMS (brief interview for mental status) score of 13/15 or no cognitive impairment. The MDS noted R46 displayed no hallucinations, no delusional behaviors, no physical or verbal behaviors, displayed no rejection of care, and displayed no wandering behaviors. The care plan had a problem dated 11/6/13 of placement at the Faribault Care Center was appropriate for long term care; on the secured unit; an elopement risk; had a history of leaving facilities to look for alcohol. The care plan did not include interventions related to re-assessment for continued placement on the locked dementia unit. Review of the documentation revealed no elopement attempts had occurred since admission. During an interview on 3/10/14 at 6:30 p.m. the administrator (ADM) stated that she was not sure why R46 was in the dementia unit except because he was an elopement risk. ADM stated she did not think this was an appropriate placement.	2 540		

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2 540	Continued From page 6 During an interview on 3/13/14 at 12:10 p.m. the direct of nursing (DON) stated she believed R46 could climb out even with the locked fenced area. DON added she would like to see R46 in an age appropriate facility. During an interview on 3/13/14 at 1:00 p.m. the social service designee stated she was not able to find any social services documentation related to dementia unit placement for R46. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that upon admission, a comprehensive assessment is conducted each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. The director of nursing or designee could monitor to assure that residents are appropriately assessed to determine placement in the dementia/memory care unit at the time of admission. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan	2 560		

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2 560	Continued From page 7 required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care for 2 of 3 residents (R40, R70) identified as a fall risk, failed to develop a plan of care that included non-pharmacological interventions for 2 of 5 residents (R40, R27) reviewed for unnecessary medications. Findings include: R70 experienced three, unwitnessed falls, in his bedroom. The falls occurred on 3/5/14, at 12:53 a.m., on 3/6/14, at 6:45 p.m. and on 3/9/14 at 11:07 a.m. Review of the plan of care for R70 with an initiation date of 1/10/14, and a revision date of 1/20/14 revealed that there were no goals or interventions addressing falls or falls with fracture. R70's active diagnosis from the minimum Data Set (MDS) form dated 1/16/14, lists but is not limited to, hypertension, anxiety and muscle weakness. The MDS further indicated a history of falls with fracture 2-6 months prior to admission. The Care Area Assessment addresses falls as a risk for R70. R70's Brief Interview for Mental Status (BIMS) dated 1/16/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact.	2 560		

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2 560	Continued From page 8 When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address the resident's history of falls and did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care plan (on admission) should have addressed falls with interventions since the resident had a history of falls. R27's plan of care did not address parameters for use of an anti-anxiety medication and did not address use of non-pharmacological interventions prior to the administration of anti-anxiety medications. R27 was on multiple scheduled psychotropic medications, which were	2 560		

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2 560	Continued From page 9 not addressed on the plan of care. R27 Admitted 2/3/2014 with dx (from care plan) altered mental status, traumatic amputation of toes, sedative/hypnotic /anxiolytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal reflux, opioid type dependence abuse, dissociative identity disorder, drug-induced psychotic disorder with hallucinations, paranoid schizophrenia, A physician order dated 2/3/2014 identified R27 on Clonazepam 0.5 mg twice daily as needed for severe anxiety. The other scheduled psychoactive medications were Buspar, Elavil, Zyprexa, and Trilafon. Medication sheets dated 2/2014 and 3/2014 were reviewed. The resident used the as needed clonazepam (antianxiety medication) several times in both months. The scheduled other psychotropic medications were given as ordered. R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The care plan lacked documentation regarding the use of the as necessary anti-anxiety medication and did not address what non pharmacological interventions were to followed before giving the as needed anti anxiety medication. The clinical record also lacked documentation of non-pharmacological interventions attempted prior to the administration of as necessary antianxiety medication. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of as necessary (prn) antianxiety medication and stated that non	2 560		

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2 560	Continued From page 10 pharmacological interventions should be attempted prior to the as needed anti anxiety medication. DON stated the care plan should have been developed to identify the use of the prn medication and the non pharmacological interventions. R40's care plan did not address the use of as needed antianxiety medication for sleep and anxiety, monitoring, and use of non-pharmacological interventions prior to administration of the medication. A Discharge summary from the hospital dated 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed. R40 admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder, paralysis agitans, compression of brain, parkinson's disease, hx of alcohol use, intracerebral hemmorrhage, obstructive hydrocephalus, insomnia (on MD notes 1/29/2014) A physician order dated 1/16/2014 identified Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety; and Lorazepam 0.5 mg (4 tabs of 2 mg.) by mouth at bedtime as needed for sleep. R40's medication sheets were reviewed: Lorazepam (antianxiety medication) was used as necessary for sleep and/or anxiety: 1/14--9 times; 2/14- was used 23 times and in 3/14-it was used 8 times. A sleep evaluation, dated 1/13/2014, was reviewed. It identified the resident had difficulty	2 560		

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2 560	Continued From page 11 staying asleep; related to pain; did not have a history of taking sleep medications routinely prior to bedtime. An average length of nap was 1-2 hours. R40 had neurological deficits (stroke, Parkinson's disease, seizure disorder). No environmental factors contributing to resident sleeping difficulties was identified. The assessment was a collection of data but did not contain a summary or analysis of the data to determine a plan. R40's care plan with initiated date of 1/14/2014 and print out date of 2/20/2014 was reviewed. It did not address R40's sleep issues or use of as needed antianxiety medications. The care plan lacked documentation regarding what non pharmacological interventions should be attempted before giving the as needed anti anxiety medication. The clinical record also lacked documentation of non-pharmacological interventions to be attempted prior to the administration of medication. On 3/13/2014 at 11:45 a.m., a trained medical assistant (TMA)-C was interviewed regarding use of the antianxiety medication. TMA-C indicated she did not give the medication during the day and indicated R40 was given the medication at night for sleep. TMA-C stated the resident got anxious but rarely used it throughout the day because the resident was up and about. The TMA did not know if there was criteria to use prior to giving the medication. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the DON was interviewed regarding criteria for use of antianxiety medication. She stated they should	2 560		

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2 560	Continued From page 12 be using non pharmacological interventions prior to administering the medication and should also be following up for effectiveness. DON also checked for sleep monitoring for R40 and indicated it was not being done, DON said that the sleep plan for R40 was not based on sleep assessment data. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies and procedures are updated, implemented, that staff are trained and that monitoring is done to assure resident care plans are developed for residents at risk for falls and that non-pharmacological interventions are addressed, attempted and evaluated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the care plan was followed for 1 of 3 residents (R25) observed with urinary incontinence and 1 of 3 residents (R4) who required assistance with hearing aides.	2 565		

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2 565	Continued From page 13 Findings include: R25 did not receive incontinence care in accordance with the plan of care. During three observations incontinence care exceeded the 2 hours as noted in the care plan. The care plan printed 2/13/14 was reviewed. The care plan had a focus of, "staff assist with toileting" and directed staff to offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 pm to 7:30 p.m.R25 was observed to be lying on his back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/12/14 R25 was observed from 10:25 a.m. to 1:30 p.m. R25 was not observed to be provided continence cares for 3 hours. Nursing assistant (NA)-J stated she had last repositioned and assisted R25 at 10:00 a.m. or a total of 3.5 hours. R25 was observed on 3/12/13 at 12:00 p.m. to 1:30 p.m. At 1:30 p.m. R25 received incontinence care (by observation 1.5 hours) NA-J stated she had last provided cares to R25 at 10:00 a.m. (a total of 3.5 hours) On 3/13/14 R25 was observed from 7:09 a.m. to 8:58 a.m. and no incontinence cares were provided. NA-C stated she had worked all night and had last changed and repositioned R25 at 5:30 a.m. (greater than 3.5 hours). The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated she would expect the care plan to be followed. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not	2 565		

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2 565	Continued From page 14 been contacted by staff related to R25 refusing to receive incontinence cares. R4 did not receive assistance with hearing aides and batteries according to the plan of care. R4's plan of care dated 12/3/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide or why the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m. R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing	2 565		

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2 565	Continued From page 15 aide was missing. About 1:00 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. On 3/13/14 at 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide last week. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that care plans are up to date, implemented, staff trained and staff monitored to assure the care plans are being followed. TIME PERIOD FOR 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.	2 830		

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2 830	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the necessary care and services were provided, based on assessment, development of a care plan, and monitoring related to pain management for 3 of 3 residents (R39, R46, R29) who were reviewed for pain and for 1 resident (R25) who was reviewed for positioning issues. Findings include: R39 was experiencing migraine headache pain and was not comprehensively assessed for pain to develop effective non pharmacological interventions to minimize pain, develop criteria to identify which as needed pain medication was to be used, document effectiveness of as necessary pain medication when administered. On 3/10/2014 at 6:30 p.m., R39 was looking for a nurse for pain medication. R39 was standing in the bedroom doorway with the call light on. The nurse shut the light off and told the resident she would get some or check on the medication. At 6:49 p.m., the resident was sitting in the bedroom in the chair and the resident indicated had a migraine and would rather not interview at that time but maybe tomorrow. At 7:00 p.m. a trained medical assistant (TMA)-C went down the hall with the medication cart but didn't stop to give R39 the requested pain medication for the migraine. At 7:10 p.m., TMA-C was interviewed and stated she was just told about the Tylenol request (40 minutes after the resident requested	2 830		

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2 830	Continued From page 17 it), as she was on break, and she was going to ask R39 what the pain medication was for and she would check and see if the resident could have it. At 7:15 p.m., TMA-C came back and said the last time the resident had the Tylenol was at 1:45 p.m. and couldn't have it because received it every 6 hours. R39 was suppose to have oxygen on continuously but wouldn't do it. The TMA indicated the resident had to wait til 7:45 p.m. then could have the Tylenol ES 500 mg 2 tabs. The TMA stated they are trying to figure out why R39 was getting the migraines and requested pain medication every night at this time. Non pharmacological interventions were not offered or attempted. On 3/11/2014 at 8:00 a.m., R39 was observed sitting in the dining room and stated didn't take bath today and was short of breath. At 10:00 a.m., was observed up and about without oxygen on and then sitting in the lobby without oxygen on. At 11:50 a.m., was observed resting in bed with the lights off. At 1:20 p.m. was in bed resting and requesting a pain medication for headache. Non pharmacological interventions were not offered or attempted. On 3/12/2014 at 7:45 a.m., R39 up and sitting on edge of bed. At 1:20 p.m. in lobby, looking out the window, and stated feeling better today, and had Tylenol for a headache. At 3:20 p.m., R39 was in bed in darkened room resting. On 3/13/2014 at 8:00 a.m., R39 was out of room and at 9:00 a.m. was in room laying on the bed resting. At 11:46 a.m., the resident was up walking back from being outside and would not respond when spoken to. R39 was readmitted to the facility on 6/12/2013	2 830		

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2 830	Continued From page 18 with diagnosis which was listed in the medical diagnoses on the computer and included: chronic obstructive pulmonary disease, hepatitis C carrier, cardiac disease, esophageal reflux, nondependent cocaine abuse, drug-induced persisting dementia, and hypertension. A quarterly Minimum Data Set (MDS) dated 9/20/2013 identified the resident with moderate cognitive impairment, on a pain medication regime, received as necessary pain medications, and occasional pain affected activities and sleep. The intensity of the pain was rated as 8. A significant change MDS dated 2/7/2014, identified the resident's cognitive status as moderate , no scheduled pain regime; as necessary pain medication offered; pain was present, almost constant, but didn't affect sleep or activities. The intensity of the pain was rated at 7. Physician notes dated 2/26/2014 were reviewed. The resident was identified with chronic tension type headache, and was on Depakote medication which was increased. A Neurology consult was recommended. (according to staff appointment is scheduled for 4/2/2014). 1/29/2014, the resident had chronic tension type headache and Ibuprofen every 6 hours was started and Depakote medication. No improvement with tramadol medication, minimal improvement with Tylenol, some improvement with morphine but daily use noted and with ongoing pain. The tramadol and morphine medications were discontinued. A pain assessment was completed on 7/12 2013 and 12/14/2013, but the data was not analyzed to come up with a summary of the pain issues, a plan identifying criteria to be used to determine which pain medication to be given and a plan for non-pharmacological interventions to be used.	2 830		

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2 830	Continued From page 19 The resident was on 3, as necessary, pain medications. The medication sheets were reviewed for the following: For 12/2013 , R39 used Tylenol 1000 mg every bedtime; tramadol 50 mg every 6 hours as necessary for headache used (8x from 12/15-12/31) and Tylenol ES 500 mg every 6 hours as necessary for pain; for 1/2014, R39 used tramadol every 6 hours as necessary 26 times, Ibuprofen 400 mg every 6 hours as needed was used 3 x for headache, acetaminophen 1000 mg ES every 6 hours as needed used many times, and morphine sulfate every hour as needed for moderate to severe pain was used many times. For 2/2014, R39 was on Imatrex 100 mg daily as necessary. The resident used it 15 times; used the ibuprofen medication many times and the acetaminophen 1000 mg ES many times. For 3/2014, the ibuprofen and acetaminophen were given several times as necessary. None of the as needed pain medications had criteria to identify when to use the medication and which of the many as needed medications to use for the resident's pain issues. Non pharmacological interventions or effectiveness of the as needed pain medication were not consistently documented. R39's care plan with print date of 2/13/2014 indicated the following: I have frequent intermittent headaches (chronic for me). Pain interferes with my ability to sleep at times, but doesn ' t interfere with my ability to do my own ADL's. My pain may be as bad as 7/10 on a pain scale. On 10-13 my provider ordered extensive testing (CD scan of sinus, neurology follow up, sleep study) and once ordered I refused all of this. Interventions: anticipate my need for pain	2 830		

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2 830	Continued From page 20 relief and respond immediately. Evaluate the effectiveness of pain interventions, I am able to call for assistance. I prefer to have pain controlled by Topamax, melatonin, Tylenol and Ibuprofen. Use of narcotics is discouraged due to history of poly-substance abuse. monitor for side effects of pain med, prior to administering as necessary Tylenol, utilize non-pharmacological interventions such as ice for my head, relaxation techniques, document effectiveness. On 3/13/2014 at 12:30 p.m., a trained medical assistant (TMA)-C was interviewed regarding use of as needed (prn) pain medications and documentation. TMA-C stated they are to document prn pain medication on back of MAR (medication administration record) and effectiveness or follow up, but not always completed. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the director of nursing (DON) was interviewed regarding pain assessments and use of as needed pain medications. She indicated the pain assessments were data collection but an analysis of the data was not completed to determine a plan. The use of prn (as necessary) pain medication should be documented on the MAR and follow up for effectiveness should be on the MAR. The staff were to use a pain management form in front of the MAR for each resident which included all the components. When checked, the MAR's did not have the pain management forms and the DON stated the staff were not doing it. There should be criteria related to which pain medication to use and when and she could not find the criteria. The DON also stated Non pharmacological interventions should be attempted prior to the	2 830		

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2 830	Continued From page 21 medication administration. R46 lacked a comprehensive pain assessment, lacked a plan of care with non-pharmacological interventions for pain and lacked monitoring related to pain management. R46 was admitted to the facility 11/5/13. The care conference summary dated 11/25/13 indicated R46 had diagnoses that included alcohol induced persisting dementia, bipolar disorder, and traumatic brain injury. Physician orders signed 2/5/14 include ibuprofen 400 mg 1 tab by mouth three times daily as needed for pain, lidocaine 5% patch apply 1 patch and change daily on for 12-hours off for 12-hours, During an interview on 3/10/14 at 5:00 p.m. R46 stated he had pain but would not rate it. Stated he had numb feet. On 3/13/14 at 7:45 a.m. R46 was asked if he had pain. R46 stated he had ankle and foot numbness and that was where he wanted the lidocaine patch placed. R46 also stated he had back pain that he rated at a 7 out of 10. R46 stated he did not want the lidocaine patch placed on his back because it would not stay put. R46 was observed on all days of the survey 1/10/14 through 3/13/14 to transfer between surfaces, come to a stand, and walk without difficulty. The medication administration record was reviewed. As needed ibuprofen was given twice in January for complaints of back pain. The documentation of nursing observations did not document the intensity of the pain or if any non-pharmacological interventions had been attempted or if the medication had been effective.	2 830		

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2 830	Continued From page 22 The as needed ibuprofen was given 6 times during February. Nursing observations were recorded four times indicating the medication was given for mouth pain but lacked intensity of the pain or if any non-pharmacological interventions had been attempted. Three of the four observations indicated relief. Ibuprofen was given once during the first 2 weeks of March. Nursing observations did not record the medication was administered. The treatment administration record was reviewed. Pain was documented once per shift each day. The documentation indicated R46 did not experience pain The facility's pain assessment was completed on 2/5/14. The assessment indicated the resident experienced pain frequently that was rated at 4 on a scale of 00-10 (mild to severe intensity not addressed). The care area assessment (CAA) for pain dated 11/25/13 indicated the resident experienced pain at a scale rating of 6 and that the pain was almost constant. The analysis of findings indicated R46 had pain related to an ankle injury and was being managed by the physician. The CAA did not evaluate the frequency or intensity of pain, if there were any non-verbal indicators of pain, or any associated signs and symptoms related to the pain, any potential causal factor of pain, or the effectiveness of any pain management program. The plan of care printed 2/18/14 indicated a focus of pain medication with an intervention to administer medication as ordered. The plan of care did not identify where the pain was located and any non-pharmacological interventions to assist the resident to manage his pain.	2 830		

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2 830	Continued From page 23 During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated with as needed pain medications nurses were to document pain location, intensity and effectiveness. DON stated she had just updated the care plans, but that all nurses were responsible for keeping the care plans current. R29 lacked a comprehensive pain assessment and the development of a plan to manage the residents pain. R29 was observed on 03/11/2014 at 10:27 AM. R29 was slow to come to a sitting position in the bed. R29's face appeared pained. R29 stated her back hurt. R29 also stated that her mouth burned because of decayed teeth. R29 was observed during noon lunch on 3/12/14 at 12:23 p.m. R29 was eating a regular diet independently and was spitting out what she called meat because her mouth burned. R29 was admitted to the facility in 2009. R29 had diagnoses listed on the medication administration record as osteoporosis, depression, dementia, and pain. R29 had a physician's order for Acetaminophen 325 mg tablet. 2 tabs by mouth 4 times daily for pain. No as needed medication (PRN) orders were found. The physician documentation of 1/15/14 noted the resident complained of back pain intermittently and had a diagnoses of lumbago. R29 had a physician's order dated 10/12/11 for Tylenol 325 mg tablets 2 tabs four times daily. The quarterly Minimum Data Set (MDS) dated	2 830		

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2 830	Continued From page 24 1/13/14 indicated R29 had a score for brief interview for mental status (BIMS) of 6 or severe cognitive impairment. The MDS identified R29 had pain and that no non-medication interventions were used. The frequency and intensity of the pain was not noted. The care area assessments (CAA) dated 8/5/13 was reviewed. The nutritional status CAA noted "presumably the lack of concentration on the BIMS is a result of the oral pain." The pain status CAA noted : numeric rating scale for pain at a 6 and that resident indicated she had pain almost constantly. The CAA noted pain managed by Tylenol currently. The facility pain assessment dated 1/11/14 indicated denied pain, but stated she experienced pain occasionally. R29 rated her pain on a scale of 00-10 at a 3 or mild. The assessment indicated R29 would display facial expression when in pain and received scheduled Tylenol. The assessment did not indicate where the pain was located, what were potential causal factors of the pain and if an assessment for the cognitively impaired adult with pain had been conducted. The care plan printed 2/13/14 had a focus: reports moderate pain frequently related to arthritis of hips and back. Interventions: scheduled use of Tylenol. Administer medication as per MD orders and note the effectiveness. Give PRN meds for breakthrough [no PRN medications ordered] acknowledge presence of pains and discomfort. Document/report complaints and non-verbal signs of pain; The care plan lacked non-pharmacological interventions to assist R29 to manage her pain. Care plan problem focus: dental health problems as indicated by occasional oral pain. The interventions included: coordinate arrangements	2 830		

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2 830	Continued From page 25 for dental care. Monitor/document/report to MD PRN symptoms of oral pain needing attention. The care plan lacked non-pharmacological interventions to assist R29 to manage her oral pain. The director of nursing (DON) was interviewed on 3/13/14 at 12:36 p.m. DON stated she was aware of dental issues, but unaware of the resident ' s mouth burning. DON stated she was not sure the facility had a pain assessment for the cognitively impaired, but did know that pain had been an issue for R29. DON stated R29 complained of back pain last week. DON stated the care plan should be revised as necessary and that staff should follow the plan of care. R25 was not provided appropriate positioning when in the wheelchair or when in bed during meals. R25 was observed on 3/10/14 from 4:00 p.m. to 7:30 p.m. lying in bed with the head of the bed elevated. At 6:05 p.m. R25 received his meal and the head of the bed was elevated further. R25 was observed to have feet extended beyond the foot of the bed and was not positioned so that he sat in an upright position to eat safely. Licensed practical nurse (LPN)-I repositioned the resident higher in the bed by pulling the resident up without assist of 2 staff members. On 3/13/14 at 8:25 a.m. R25 was observed lying in bed with head of bed elevated and a breakfast tray had been provided to the resident. Registered nurse (RN)-A came to the resident's room to observe the resident. RN-A stated the resident was not positioned in order to eat the meal safely and left to find someone to help with assisting the resident to reposition in the bed.	2 830		

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2 830	Continued From page 26 The care area assessment for nutritional status dated 11/7/13 did not identify R25's safety with positioning and eating in bed. The care plan printed 2/13/14 identified a focus/problem of need assist with ADLs. Interventions included assist of 2 to boost up in bed dated 2/17/14, independent with eating, but did not direct the resident was to eat in bed and the safe positioning to eat in bed. On 3/11/14 at 9:30 a.m. R25 was observed sitting in the wheelchair. R25's back was not against the back of the wheelchair, R25's feet were on the floor, R25's was sitting forward in the chair so that his thighs were beyond the edge of the chair. The wheelchair cushion was beyond the front edge of the chair. When asked R25 stated he was not comfortable sitting in the chair. On 3/13/14 at 8:30 a.m. occupation therapist stated she had just provided R25 with a larger wheelchair and new cushion, but that she had not assessed R25 for wheelchair positioning. The care plan printed 2/13/14 identified a focus/problem of need staff assist with mobility. Interventions included use a wheelchair for mobility on the unit, will refuse to reposition almost every time. Explain why it has to be done and ask again kindly. If I am non-compliant it needs to be reported to nurse and if nurse cannot convince me to reposition, report to director of nursing During an interview on 3/13/14 at 11:45 a.m. the director of nursing (DON) indicated staff were expected to follow the care plan. If the resident would refuse cares, staff should then re-approach	2 830		

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2 830	Continued From page 27 the resident. DON stated she was unaware R29 had refused to be repositioned. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are reviewd, revised as necessary, staff are trained and monitored to assure all residenst 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. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced	2 910		

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2 910	Continued From page 28 by: Based on observation, interview and document review the facility failed to ensure a comprehensive urinary incontinence assessment and provision of services for 2 of 3 (R25, R46) residents reviewed for incontinence. Findings include: R25 lacked a comprehensive incontinence assessment that included voiding patterns and lacked provision of services in accordance with the plan of care R25's quarterly Minimum Data Set (MDS) dated 1/24/14 was reviewed. The MDS identified diagnoses of dementia, depression, psychotic disorder. The MDS of 1/24/14 indicated R25 had total dependence on two staff for activities of daily living-including toileting care; did not have a toileting plan, and was always incontinent. The Urinary and Bowel Continence Risk Assessment checklist dated 2/13/14 indicated R25 had incontinence related to mental confusion and impaired mobility and therefore had functional incontinence. No analysis of data was documented. The Urinary Continence Intervention Guideline Tool dated 2/13/14 had a completed check list that identified R25 as having functional incontinence and recommended an assessment for pain, scheduling of a 3 day bladder elimination tracking to establish elimination pattern, and implementing prompted voiding. The Tool did not have an analysis of data to determine why the recommendations were noted and what the outcome of the bladder elimination tracking was. The Urinary and Bowel Continence Risk Assessment and Urinary Continence Intervention Guideline Tool did not	2 910		

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2 910	Continued From page 29 identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. A care plan was not developed based on assessments and evaluation. The care area assessment (CAA) dated 11/7/13 indicated R25 required extensive assistance for toileting and was always incontinent. The analysis of findings noted R25 was highly resistive to toileting. The CAA identified urinary urgency, diabetes, congestive heart failure and depression as contributing factors, but did not identify the type of incontinence or the voiding pattern/frequency. The CAA did not provide a plan of care based on the evaluation. The care plan printed 2/13/14 was reviewed. The care plan had a focus of "staff assist with toileting" and directed staff offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 p.m., to 7:30 p.m., R25 was observed to be lying on back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/11/14at 11:10 a.m., while visiting R25, a strong urine odor was detected. On 3/11/14 at 1:30 p.m. R25 was observed sitting in the wheelchair. A strong urine odor was detected and the crotch of R25's pants was observed to be wet. On 3/12/14, R25 was observed from 10:25 a.m. to 1:30 p.m. R25 was not observed to be provided incontinence cares for 3 hours. Nursing assistant (NA)-J stated she had last repositioned and assisted R25 at 10:00 a.m. or a total of 3.5 hours. R25 was observed on 3/12/13 at 12:00 p.m. to 1:30 p.m. At 1:30 p.m. R25 received	2 910		

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2 910	Continued From page 30 incontinence care (by observation 1.5 hours) NA-J stated she had last provided cares to R25 at 10:00 a.m. (a total of 3.5 hours) On 3/13/14 R25 was observed from 7:09 a.m. to 8:58 a.m. and no incontinence cares were provided. NA-C stated she had worked all night and had last changed and repositioned R25 at 5:30 a.m. (greater than 3.5 hours). During an interview on 3/12/13 at 1:30 p.m. NA-J stated two soaker pads were under the resident when in bed because he "wets a lot and this prevents soak through." The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated the urinary incontinence assessments were just being completed. The assessment was to include a 72 hour bowel and bladder diary to see if a pattern exists. The notations on the assessments should be included on the care plan. DON stated she would expect the care plan to be follow. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to receive incontinence cares. R46 lacked a comprehensive assessment and plan of care for incontinence. R46 was observed on 3/10/14 at 4:10 p.m. A strong urine smell was noted. Licensed practical nurse (LPN)-I stated he also noticed the odor but was unsure if the odor was from R46 or another resident. LPN-I stated R46 did not like to get cleaned up. No staff interventions related to the incontinence or odor was observed. On 3/12/14 at 10:05 a.m. and at 10:25 a.m. R46 was observed sitting by the nursing station with 3 staff	2 910		

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2 910	Continued From page 31 members present. A strong urine smell was noted. No staff interventions related to incontinence and odor were observed. On 3/13/14 at 7:10 a.m. a strong urine odor was detected. R46 was observed to be wearing the same clothing as the previous day. During an interview on 3/13/14 at 7:50 a.m. nursing assistant (NA)-C verified a strong urine odor, when near F46. NA-C stated R46 was to get a shower twice a week. NA-C was not observed to intervene. R46 was admitted 11/5/13. The Care Conference Summary dated 11/25/13 identified diagnoses of alcohol-induced persisting dementia, bipolar disorder, and traumatic brain injury. The admission Minimum Data Set (MDS) dated 11/12/13 and the quarterly MDS dated 1-12-14 both identified R46 as having a BIMS score (brief interview for mental status) of 13 or no cognitive impairment and to always be continent. The treatment record for November and December documented R46 was to get a shower every other day due to incontinence but documented the resident frequently refused or was not given the opportunity. The Care Conference Summary dated 11/25/13 noted resident "will uninate [sp] in pants and refuse to change." On 3/4/14 the facility completed Urinary and Bowel Continence Risk Assessment. The checklist identified impaired bladder emptying without documentation of a post void residual or that a physician exam had been completed, identified nocturia, and determined the resident demonstrated characteristics of overflow	2 910		

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2 910	Continued From page 32 incontinence and characteristics of over active bladder/urge incontinence. The assessment did not identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. The assessments did not provide a plan of care based on the evaluation. No CAA was found or provided for urinary incontinence. Review of the care plan dated 2/18/14 did not reveal a plan/interventions to assist R46 to manage incontinence. The care plan identified the resident as independent with activities of daily living. The care plan also directed if the resident refused cares, the director of nursing was to be notified. The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated the urinary incontinence assessments were just being completed. The assessment was to include a 72 hour bowel and bladder diary to see if a pattern exists. DON stated she had not been notified of refusal of cares. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are current, that staff are trained and monitored to assure each resident is assessed for toileting needs and that a continuous program of bladder management is implemented and evaluated to reduce incontinence and that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. TIME PERIOD FOR CORRECTION: Twenty One	2 910		

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2 910	Continued From page 33 (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provision of grooming for 1 of 1 resident (R25) observed who required assistance with grooming. Findings include: R25 lacked personal grooming to remove facial hair. Review of the quarterly Minimum Data Set (MDS) dated 1/24/14 identified diagnoses of diabetes, dementia, depression, psychotic disorder. The MDS indicated a total dependence of two staff for activities of daily living. R25 was observed throughout the survey of 3/10/14 through 3/13/14. On 3/11/14 at 9:30 a.m. R25 was noted to be unshaven. On 3/12/14 at 10:25 a.m. R25 was noted to be unshaven. On 3/13/14 at 9:30 a.m., R25 was again observed to be unshaven. R25 was interviewed on 3/11/14 at 8:38 a.m. R25	2 920		

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2 920	Continued From page 34 stated that staff would only shave him every other day and had not shaved him this day. The care plan printed 2/13/14 identified a focus of behavior problems. Interventions directed if resistive to cares staff should have a nurse determine the option that is least detrimental; leave and re-approach later if continued to be resistive. The care plan identified a focus of resistive to care with interventions that directed if resist ADLs, reassure, leave and return 5-10 minutes later and try again. The care plan identified a focus needs assist with ADL's and interventions for grooming that directed staff need assist of 1 staff and encourage participation to comb own hair and brush teeth. The interventions did not provide staff with directions related to shaving. During an interview on 3/12/14 at 1:30 p.m. nursing assistant (NA)-J and trained medication aid (TMA)-E stated R25 was last shaved on Friday and that R25 did not always agree to be shaven. The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated she would expect shaving to be included in the care plan and for the care plan to be followed. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to be shaved. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming,	2 920		

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2 920	Continued From page 35 and personal and oral hygiene. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the provision of thickened liquids as ordered by the physician for 1 of 1 resident (R29) reviewed with thickened liquids. Findings include: R29 was not provided thickened liquids during meals. R29 was admitted to the facility in 2011 and had diagnoses that included diabetes, Alzheimer's, depression, according to the physician orders signed 1/31/14. R29 was observed on 3/12/14 at 12:20 p.m. eating lunch independently. R29 had been	2 965		

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2 965	Continued From page 36 served a regular diet with regular liquids. On the tray were a glass of water, a glass of juice and a cup of tea. At 12:30 p.m. trained medication aide (TMA)-E placed a spoon into each glass and stated the fluids were of thin consistency. TMA-E stated she had not observed R29 to cough while eating. R29 was observed during the morning meal on 3/13/14 at 8:15 a.m. R29 was served a regular diet and thin liquids (orange juice, prune juice, milk, water.) TMA-F stated the liquids were thin. Nursing assistant (NA)-C stated R29 had never had thickened liquids since NA-C had started working in the facility a year ago. TMA-F verified on the medication administration record R29's liquids were to be nectar thick and proceeded to use thickener. The physician orders dated 10/26/13, 11/27/13, 12/31/13, 2/5/14, 3/12/14 all ordered Liberal ADA/mechanical soft with nectar thick liquids. Ok for thin milk on cereal. On 2/12/13 the speech therapist recommended nectar thick liquids. The tray card on the meal tray identified the resident was to receive nectar thick liquids. The care area assessment (CAA) dated 8/5/13 did not identify type of diet R29 was to receive. The quarterly Minimum Data Set (MDS) dated 1/13/14 indicated R29 was able to eat with limited assist of one staff, had no swallowing disorder, was on a therapeutic diet, and did not have speech therapy. The dietitian notes of 3/12/14 noted R29 was to receive a liberal ADA diet with nectar thick liquids. Review of the care plan identified a problem initiated 6/7/11 and revised on 10/11/13 that stated R29 had a swallowing problem related to difficulty with regular food. Coughing or choking during meals or swallowing medication.	2 965		

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2 965	Continued From page 37 Interventions dated 4/20/13 indicated diet to be followed as prescribed: liberal diabetic, mechanical soft textures with thin liquids. During an interview on 3/13/14 at 8:33 a.m. the administrator stated she was aware the liquids were to be thickened and had not been. During an interview on 3/13/14 at 1:00 p.m. cook-C stated she was unaware of the need for the thickened liquid until today when she received a note from licensed practical nurse (LPN)-J that the diet order was changed to thin liquids. LPN-J was interview 3/14/14 at 1:10 p.m. and stated that since last August when LPN-J started working in the facility, R29 had not received thickened liquids. SUGGESTED METHOD OF CORRECTION: The director of nursing could review policies, train staff and monitor staff to ensure the provision of thickened liquids as ordered by the physician are provided to residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 965		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		

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21390	Continued From page 38 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during dressing change for 1of 2 residents (R45) with a gastric tube dressing and tube feeding, failed to ensure isolation precautions were adhered to for 1 of 1 residents (R48) with isolation precautions and failed to assure 1 of 1 residents (R10)Nebulizer equipment was sanitized between use. Findings include: R45 had a gastric feeding tube and during dressing change, infection control practices were not implemented to prevent spread of infection.	21390		

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21390	Continued From page 39 R45 was readmitted on 12/26/2013 with diagnoses (listed from the care plan) that included: encephalopathy, dysphagia, history of traumatic brain injury, post traumatic seizures, dementia with behavioral disturbances, episodic mood disorder, schizophrenia, and CVA (stroke). During observations, on 3/11/2014 at 9:20 a.m., LPN-C went into R45's room to do a dressing change around the gastric tube. LPN-C gloved and removed the dressing which had a tiny bit of blood tinged drainage on it. Without changing gloves, the LPN opened drawers and touched packaged supplies, the resident's chair, door handles to the closet, a blood pressure cuff, bag containing oral toothettes, and a mat which was leaning against the closet. Keeping the same gloves on, the LPN took water from a pitcher and use a Q-tip to clean around the gastric tube stoma area. Slight pinkish drainage was noted on the Q-tip. LPN-C then touched the medication and feeding syringe and tube extension. LPN-C snapped the extension on the gastric tube and checked for patency using a stethoscope. When attempting to administer water, the water did not go in. LPN-C had to use the stethoscope again to listen for patency. At that point, the LPN-C was wearing the same soiled gloves and touched the resident's skin, the stethoscope and the tubing. She disconnected the extension tube and took it into the bathroom to rinse it out. The LPN -C did not change the soiled gloves and continued to reapply the extension tube to the gastric tube. Without changing the soiled gloves, the LPN-C continued to administer water and medication through the tube using the same syringe. After LPN-C was finished with the medication task, she did not have gauze to put around the stoma area. She removed the soiled gloves and went out to the medication cart to find the gauze. The LPN	21390		

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21390	Continued From page 40 gloved and put the gauze around the stoma. On 3/12/2014 at 11:00 a.m., the director of nursing (DON) was interviewed regarding lack of infection control procedures used with R45's dressing change to the gastric tube site. The DON stated the nurse's should be following standard precautions and also the facility policy for dressing changes that are not sterile. A policy was requested and provided by the facility. A policy for Dressing-Non-sterile Treatment revised 6/2013 was reviewed. It identified: "6. Place supplies on clean field. 7. Wash hands. 8. Apply clean gloves. 11. Remove soiled dressing and dispose of in bag. Remove gloves. Wash hands. 12. Apply clean gloves. 13. Clean wound per physician orders. Cleanse wound from center to outer boarders using a circular motion (area of most contamination to area of least). Ensure you do not touch other skin surfaces, furniture, bedding, etc., and return to wound bed as this will contaminate the wound bed. 14. Dispose of cleaning supplies in bag. 15. Remove gloves and wash hands. 16. Apply clean gloves. 17. Apply dressing as ordered." R48 had respiratory methicillin resistant staph aureous (MRSA) with a tracheostomy and infection control precautions were not consistently implemented. A physician note dated 3/5/2014 identified history of present illness: Respiratory: Patient with chronic tracheostomy and with increased cough shortness of breath and sputum culture showed MRSA and Pseudomonas and started on IV	21390		

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21390	Continued From page 41 antibiotics. Treatment for bronchopneumonia: possible pneumonia with sputum with pseudomonas and MRSA. On 3/10/2014 at 5:20 p.m. R48's room door was closed. A note to check at nurse's station was on the wall at the doorway. A plastic cupboard at the doorway contained gowns, gloves, masks, red bags, and a blood pressure cuff and thermometer. On 3/11/2014 at 8:00 a.m. R48 was observed ambulating in the hall with a walker and had a mask over a trach site and then stood at the medication cart waiting for medications. At 9:00 a.m., R48 was observed to come out of the room with the mask off the trach site. A licensed practical nurse (LPN)-C puts a mask over the trach site and tells the resident it needed to be on because of an infection the resident had. LPN-C stated the resident was on precautions related to respiratory methicillin resistant staph aureos (mrsa). LPN-C gloved and put a mask on and stated she didn't gown because the resident didn't spit. She wore a mask because of droplets in the air and coughing from the trach and R48 was not good about leaving a mask on. The LPN went into the resident room and assisted the resident out of the bathroom. The resident took the mask off the trach and sat on the edge of the bed. At 9:47 a.m., R48 came out of the room with a mask over the trach and stands by the medication cart. The LPN touched the resident's walker to redirect the resident away from the cart and then without cleansing her hands continued to set up medications. At 10:00 a.m., R48 removed the mask and threw it on top of a waste basket on the cart but it just laid on top of the basket. LPN-C applied a new mask and	21390		

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21390	Continued From page 42 continued to set up the medication without washing her hands. At 2:05 p.., R48 came ambulating out from room to nurse's desk without a mask over the trach. The resident's room is the second door down the hall and so the resident walks a distance to get to the nurse's station. The nurse saw the resident and got a mask. On 3/11/2014 at 10:00 a.m., R48 walked into the nursing station and stood over NA-K who tried to redirect the resident back to his room since the tracheostomy was not covered. On 3/12/2014 at 7:45 a.m., R48 was observed up with walker at nurse's desk, however, had a mask on trach site. At 9:45 a.m., R48 was observed ambulating in the hallway with walker and no mask on. LPN-C tried to redirect the resident, touched the walker, and continued to set up medication, without washing hands, while the resident stood there. LPN-C indicated she didn't wear a gown in the room but just a mask and gloves because the resident didn't cough or spray and she didn't even during suctioning because everything goes up the tube and there is no spray there. At 10:00 a.m., LPN-C entered the room with mask and gloves on. There were no gowns in the container outside the room. The resident is already laying in bed. The LPN pulled on the incontinent cloth pad under the resident, moved the resident ' s feet, touched the linens and then the resident's forehead. With her gloves still on, she raised the bed with the controls. Without changing gloves, LPN-C removed the mask over the resident's trach, touched the dressing around the trach, and then removed the inner cannula and disposed of it in the wastebasket. Then removed the soiled gloves (had mucous on them) and regloved. The LPN Opened up the new	21390		

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21390	Continued From page 43 package of cannula and put it in the trach site. With the gloves still on, the LPN administered the neb medication into the neb mask and extension and started it up and placed it on the resident over the trach. She got out a new feeding syringe and dated it, poured water into a pitcher, touched the resident clothing and dressing to the feeding tube. Went into her pocket for something and then removed the tip of the syringe and put an extension on the feeding tube. She put the syringe in the tubing with air in it and takes a stethoscope to check for placement. The LPN retrieved 2 cans of feeding formula out of the box in the room, while holding the feeding syringe without a cap on it next to her clothing. Without changing gloves, or the feeding syringe, the LPN puts the syringe into the extension tube to the tube feeding and gives the resident the medications and water flushes. After finishing , the LPN then unhooked the extention tube and recapped the syringe tube. Without changing her gloves, she touched around the stoma skin site of the tube feeding and then readjusted the nebulizer mask and parts, then put on a clean dressing to the tube site. The bathroom did not have any soap in the dispenser. But the LPN indicated she had sanitizer on her medication cart. When checked, the sanitizer was not on the cart and another staff had to retrieve some. At 3:15 p.m., R48 had been out at nurse's desk several times, however the resident did have mask on over the trach site. On 3/12/2014 at 10:30 a.m., LPN-C verified she did not change her gloves appropriately throughout the procedures for R48. On 3/12/2014 at 12:45 p.m., LPN-J went into R48's room without putting on a mask and gloves or gown. She laid a cloth chux on the resident's	21390		

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21390	Continued From page 44 bed and straightened it out touching linens. The resident had a mask over the trach but was noted to cough. When the LPN-J went into the bathroom to wash her hands she noted there was no soap in the dispenser. She went to the soiled utility room to wash her hands. It was 2 doors down from the resident's room. LPN-J told the housekeeper the resident's bathroom needed soap and the housekeeper went in and filled the dispenser. On 3/12/2014 at 12:49 p.m., a nurse aide (NA)/medical records (MR) (NA)-K/(MR)-K walked into R48's room without a mask, or gloves or gown on. The aide directed the resident into the room and touched the walker and the resident on the back. The resident wanted assistance to get into bed. The aide walked out without washing her hands. NA-F put her gloves on and mask and went in to assist the resident into bed. NA-F was interviewed about the resident and use of a mask over the trach area. She indicated the nurse aides put a mask over the trach when they do cares on the resident . If they see R48 come out of the room, they redirect the resident back to the room and encourage the resident to put a mask on or they do it for the resident. The resident was independent with toileting and washing own hands. On 3/13/2014 at 6:45 a.m. , LPN-B was observed in R48's room suctioning the resident. The resident was coughing. LPN-B did not wear a mask but had gloves on. No gowns were available in the cabinet outside the resident's door. At 8:30 a.m., R48 came out to nurse's desk without a mask on and 2 staff (NA-K, LPN-J) walk by the resident for several minutes before redirecting the resident to get a mask on.	21390		

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21390	Continued From page 45 On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. R48 was placed on precautions because the resident had a positive culture for MRSA respiratory. Interviewed the DON on observations of poor handwashing and glove exchange, lack of soap in the bathroom, lack of gowns in the cupboard and also discussed observations of resident leaving room without a mask and sometimes being directed and other times not. The DON indicated the staff should be following the precautions because the resident was positive for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precaution sign was placed at the doorway of the resident's room. On 3/13/2013 at 2:00 p.m., R48 walked into the nursing station and stood over RN-A for several minutes until RN-A was able to direct R48 back to his room as the tracheostomy was not covered. On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was interviewed. and verified R48 had a problem coming out to the desk area and in the hallways without keeping the trach area covered as directed by facility protocol. On 3/13/2014 at 1:30 p.m., the DON was again interviewed regarding infection control procedures. She stated "[R48], we are unable to keep him in isolation so he is in what we call precaution, but he does not follow through with that either. We are constantly taking him to his	21390		

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21390	Continued From page 46 room and reapplying the masks to cover the trach (tracheostomy)." NEBULIZER EQUIPMENT WAS NOT SANITIZED BETWEEN USE: R10 s nebulizer system was observed on 3/12/14 at 10:15 a.m. to be located on his bed side stand. The nebulizer cup and tubing was attached to the machine. The nebulizer cup where the medication is placed was coated with moisture drops on the inside of the cup. Licensed practical nurse (LPN)-B was interviewed on 3/12/14 at 10:15 a.m. and said that she had set up and given R10 his nebulizer medication treatment at 8:00 a.m. However, LPN-B had not cleaned the equipment following the inhalation treatment to prevent bacterial and/or fungus growth as outlined in the facility policy. Again on 3/13/14 at 1/17 p.m. R10's nebulizer was noted to be fully connected and this time there was a white film coating the entire inside of the nebulizer cup. On asking R10 about the use and care of the nebulizer equipment at this time R10 said, "They [referring to facility staff] don't ever clean it." R10 said that he had used the nebulizer equipment earlier in the day and no one has touched it since then. On 3/13/14 at 2:00 p.m. trained medication assistant (TMA)-A was asked about the use and cleaning of R10's nebulizer equipment following the inhalation treatment. TMA-A said that the equipment is to be taken apart and the cup is to be rinsed in water and the equipment is to air dry.	21390		

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21390	Continued From page 47 However, this had not been done following R10's inhalation treatment on 3/12/14 8:00 a.m. dose nor on 3/13/14 after 8:00 a.m. dose. The director of nursing was made aware of lack of following the facility policy on the care of the nebulizer equipment on 3/13/14 at 2:47 p.m. and she was also asked for the policy in regards to the nebulizer inhalation procedure. Facility policy Desert Health Group Small Volume Nebulizer Procedures, revised date 06/2013 read, "11. Administer therapy until the medication is depleted (about 10-15 minutes)." and "13. Disassemble device and rinse the mouthpiece and nebulizer cup with water and dry. Store unit per facility policy. Dispose of equipment per facility policy." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are current, that staff are trained and monitored to assure procedures are implemented to prevent the spread of infection when caring for residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the	21510		

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21510	Continued From page 48 required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide rehabilitative services as necessary for 1 of 1 resident (R46) reviewed. Findings include: R46 lacked a referral for rehabilitation services. R46 was admitted on 11/5/13 from an acute care hospital to the facility's locked dementia unit. R46's diagnoses listed on the preadmission screening dated 11/5/13 at Karsakoff dementia (alcohol induced dementia) and bipolar disease. The care plan printed 2/18/14 identified R46's diagnoses as alcohol induced dementia, bipolar disorder, alcohol dependence, drunkenness, acute alcoholic hepatitis. The Admission Minimum Data Set (MDS) dated 11/12/13 and the quarterly MDS dated 1/12/14 indicated R46 had a brief interview for mental status (BIMS) score of 13/15 or no cognitive impairment, displayed no behaviors, was independent with activities of independent living. During an interview on 3/10/14 at 5:13 p.m. R46 stated was admitted with a diagnosis of alcohol abuse and had not been involved in a treatment program. R46 stated he had investigated outpatient services, found some available in this community, but had not been provided access to them. R46 stated he would be willing to do outpatient or inpatient treatment. The care conference summary dated 11/25/13	21510		

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21510	Continued From page 49 noted, "Resident would like to be in a treatment facility or a facility where people are younger." The care plan printed 2/18/14 was reviewed. The resident's history with alcohol and request for treatment was not noted. During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she thought social services was working on the treatment issues. The social service designee (SSD) was interviewed on 3/13/14 at 12:57 p.m. SSD stated R46 had discussed with her the request of treatment as outpatient or inpatient. SSD stated she had contacted the guardian. SSD stated the guardian did not want R46 to go to treatment because guardian was afraid R46 would not be able to return to the nursing home. SSD stated she had also discussed treatment with the county case manager and that he had said the facility needed to get the guardian on board. SSD stated the management team stated the facility would not hold the bed for return following the 90-day inpatient treatment program so SSD did not know if a readmission bed would be available. SSD stated she had not investigated further for outpatient treatment. SSD stated she was unable to find any social services documentation from previous social worker related to treatment programs. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could monitor to assure that residents are assessed and referred to appropriate rehab services as necessary. TIME PERIOD FOR CORRECTION: Twenty One	21510		

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21510	Continued From page 50 (21) days.	21510		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop parameters for use and failed to monitor the effectiveness of as needed psycho-active medications for 2 of 5 residents (R27, R40) reviewed for unnecessary medications. Findings include:	21540		

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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
21540	Continued From page 51 R27 was on an anti-anxiety medication without parameters for use, documentation of effectiveness when used, and without use of non-pharmacological interventions; and was on multiple scheduled psychotropic medications without adequate monitoring . R27 was admitted to the facility 2/3/2014 with dx (from care plan) altered mental status, traumatic amputation of toes, sedative/hypnotic /anxiolytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal reflux, opioid type dependence abuse, dissociative identity disorder, drug-induced psychotic disorder with hallucinations, paranoid schizophrenia, A physician order dated 2/3/2014 identified R27 on Clonazepam 0.5 mg twice daily as needed for severe anxiety. The other scheduled psychoactive medications were Buspar, Elavil, Zyprexa, and Trilafon. Medication sheets dated 2/2014 and 3/2014 were reviewed. The resident used the as needed clonazepam (antianxiety medication) several times in both months. The scheduled other psychotropic medications were given as ordered. The target behaviors that were identified to be monitored included mood indicators, behavior indicators, hearing voices not there, seeing objects not there, agitation-not responding to direction, and pacing. These behaviors were documented on every shift daily. However, an analysis of the behaviors was not compiled of the data to identify effectiveness of the use of the as needed antianxiety medication and other multiple psychotropic medications (Buspar, Zyprexa, Elavil, Trilafon).	21540		

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	00989	A. BUILDING: _____ B. WING _____	C 03/13/2014

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21540	Continued From page 52 R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The use of the as necessary and scheduled psychotropic medications with interventions was not addressed. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of prn antianxiety medication. DON stated staff should be documenting in the MAR and follow up for effectiveness. They are to attempt non pharmacological interventions prior to the prn use. The documentation was not evident in the MAR or record and the DON verified that. On 3/13/2014 at 12:50 p.m., and 3:00 p.m., the DON was interviewed regarding a summary/analysis of the behavioral data to identify effectiveness of the scheduled medication and use of the as needed antianxiety medication. She indicated no analysis was done of the behavioral data. No criteria for the use of the as needed medication was provided. R40 used as needed antianxiety medication for sleep and anxiety without criteria for use, monitoring of effectiveness and lack of use of non-pharmacological interventions prior to administration. A Discharge summary from the hospital dated 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed. Admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder,paralysis agitans, compression of brain, parkinson's disease, hx of	21540		

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21540	Continued From page 53 alcohol use, intracerebral hemmorrhage, obstructive hydrocephalus, insomnia. (on MD notes 1/29/2014) A physician order dated 1/16/2014 identified Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety; and Lorazepam 0.5 mg (4 tabs of 2 mg.) by mouth at bedtime as needed for sleep. R40's following medication sheets were reviewed: Lorazepam (antianxiety medication) was used as necessary for sleep and/or anxiety: 1/14--9 times; 2/14- was used 23 times and in 3/14-it was used 8 times. A sleep evaluation dated 1/13/2014 was reviewed. It identified the resident had difficulty staying asleep; related to pain; did not have a history of taking sleep medications routinely prior to bedtime. An average length of nap was 1-2 hours. R40 had neurological deficits (stroke, Parkinson's disease, seizure disorder). No environmental factors contributing to resident sleeping difficulties was identified. The assessment was a collection of data but did not contain a summary or analysis of the data to determine a plan. R40's care plan with initiated date of 1/14/2014 and print out date of 2/20/2014 was reviewed. It did not address R40's sleep issues or use of as needed antianxiety medications with interventions. On 3/13/2014 at 11:45 a.m., a trained medical assistant (TMA)-C was interviewed regarding use of the antianxiety medication. TMA-C indicated	21540		

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21540	Continued From page 54 she did not give the medication during the day and indicated R40 was given the medication at night for sleep. The resident got anxious but rarely used it throughout the day because the resident was up and about. The TMA did not know if there was criteria to use prior to giving the medication. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the DON was interviewed regarding criteria for use of antianxiety medication. DON stated they should be using non pharmacological interventions prior to administering the medication and should be following up also for effectiveness. The DON indicated she just did an education on that on 2/17/2014. She also checked for R40 re: sleep monitoring and indicated it was not being done. DON verified they did not analyze the sleep assessment data to come up with a plan. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings,	21685		

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21685	Continued From page 55 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 and interview the facility failed to keep kitchen equipment and the kitchen environment clean and sanitary, also failed to keep the physical environment free from foul odors. Finding include: During the kitchen tour with Cook-A and Cook-B on 3/10/14 at 1:45 p.m. the following was observed: Upright freezers and refrigerators located in the kitchen had a thick layer of dust covering the grill and when the grill was moved the dust covered the entire top of the pieced of equipment. The ice machine located in the dining room was observed to have the grill covered with a thick coat of dust/debris and the reusable filter was coated with white powder type debris. The floor in the kitchen had multiple food debris scattered around the perimeter of the room. The electrical cords and water tubing connected to the appliances including the coffee maker was coated with a thick layer of dust/debris. The metal emergency pull ring located near the coffee machine had long strands of dust/debris. During the environmental tour on 3/13/14 at 8:30 a.m. accompanied by the director of maintenance	21685		

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21685	Continued From page 56 and lead housekeeper. The following was observed: The bathroom in room 113 had a strong urine odor present and the toilet had been flushed and the odor continued to be present. The housekeeper said it sometimes smells and they do clean in the bathroom. However, the urine smell continues to be present. The 300 wing was observed to have resident use equipment including wheel chair, weight chair, resident lifts lined down the west side of the hallway. Also the medication cart is placed on the west side of the hallway. There were two residents who met each other going in the opposite directions and one of them had to move into an open door way to allow the other resident pass them by. With the west side of the hallway used to store resident equipment the residents who are ambulatory do not have free access to the hand rails on the west side to the hallway. On asking the maintenance director and housekeeper it was learned that they have to use the west side of the 300 wing to store resident equipment because there is no storage room in the area to keep them. It was also learned from the maintenance director and housekeeper that this practice of keeping resident equipment stored on the west hallway has been practiced for a long time. SUGGESTED METHOD OF CORRECTION: The director of nursing, director of maintenence and/or designee could assure the physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment is kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the	21685		

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21685	Continued From page 57 residents according to a written routine maintenance and repair program. TIME PERIOD FOR 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 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 ensure the use of functioning hearing aides for 1 of 2 residents (R4) observed with hearing aides. Findings include: During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide	21810		

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21810	Continued From page 58 or why the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m., R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide last week. R4's active diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. R4's Brief Interview for Mental Status (BIMS) dated 12/30/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "I	21810		

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21810	Continued From page 59 am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." The interventions read, "I want my hearing aids left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and theft policies of the facility. I wear bilateral hearing aids. I can put them in and take them out independently. I will ask for assist if I need, especially with taking battery out." An intervention on the plan of care dated 10/25/13, read "Staff again attempted to have resident allow hearing aides kept in nurses cart for safe keeping. Resident rejected the offer. Because of history of losing hearing aides, staff will not remove anything from residents room without first assuring hearing aides are accounted for." The consultation report from audiology dated 7/16/13, under recommendations read, "Need plan from nursing home of how future loss of hearing aids will be prevented before patient is fit with replacement. Return in 2 weeks for a hearing aide fitting." The consultation report from audiology dated 9/3/13, read "1. Continue wearing both aides daily. 2. Replacing both batteries weekly, early if needed (the left uses the size 13 or orange and right uses size 675 or blue). 3. Turn hearing aids off when not in use by opening battery doors. 4. Return in 4 months for a hearing aide recheck, sooner if there are problems." A document titled Audiology office visit and dated 10/4/13, read "The right hearing aide had a size 13 battery in it instead of the 675. The tubing was twisted on both hearing aides. The	21810		

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21810	Continued From page 60 batteries were replaced in both hearing aids. The tubing was replaced. Both hearing aides are working fine now." In review of the medication and treatment sheets for March 2014, there was no area addressing the tracking of the bilateral hearing aides. The nursing assistant assignment sheet read, "Hearing Aides." but did not designate the battery size for which ear, nor did the assignment sheet direct staff to account for the hearing aides. Attempts to call the resident family were unsuccessful to discuss the hearing aides and the medical record director (MRD) validated the family was difficult to get hold of as neither had answering machines or message capabilities. The MRD did not know if the family was aware of the right hearing aide being missing. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies, procedures are updated, implemented, evaluated, monitored and that based on individual assessments, personal care based on individual needs is provided to enable residents to achieve their highest level of physical and mental functioning TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21810		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and	21855		

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21855	Continued From page 61 personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal privacy during cares for 1 of 3 residents (R25) observed for incontinence and the facility failed to confidentially post personal information for 1 of 4 residents (R46) observed smoking. Findings include: R25 lacked privacy during incontinence cares. During an interview on 3/11/14 at 9:12 a.m. R25 stated staff did not pull curtains or close doors to provide privacy during cares. R25 was observed during incontinence cares provided by nursing assistant (NA)-J and trained medication aide (TMA)-E on 3/12/14 between 1:30 p.m. and 1:50 p.m. During the cares R25 was observed to urinate on the bed linens. TMA-E was observed to open the door and leave the room without pulling the privacy curtain or providing personal privacy to R25 who was lying in bed exposed. TMA-E reentered the room again. No privacy curtain was pulled and no personal privacy was provided to R25. TMA-E was interviewed at 1:50 p.m. and stated the privacy curtain should have been pulled	21855		

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21855	Continued From page 62 before she exited the room. During an interview on 3/13/14 at 11:45 a.m. the director of nursing stated privacy was an expectation of care. R46 lacked confidentiality of personal smoking information. On 3/10/14 at 5:30 p.m. a sign was observed posted in the nursing area/dining room/resident activity area that stated [R46's name in bold typing] Smoking Schedule. The sign listed the times and mount of cigarettes R46 could smoke During an interview on 3/10/14 at 5:11 p.m. R46 stated the cigarettes were locked up and felt rights were taken away. R46 was observed on 3/12/14 at 7:10 p.m., on 3/13/14 at 7:35 a.m. outside to smoke under staff supervision. Each time R46 was observed to ask staff to be able to smoke. Review of documents identified the facility completed a smoking assessment on 2/6/14 that stated the resident required supervision, had cognitive loss, and had been observed smoking in bedroom or bathroom. The facility elopement risk assessment dated 2/6/14 noted under smoking, "will jump fence if given a chance". No assessment/ analysis of data was provided. Review of the care plan printed, 2/18/14, had a focus related to smoking The interventions directed the resident required visual supervision while smoking, that cigarettes and lighter were to be locked up.	21855		

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21855	Continued From page 63 During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she was aware R46 had smoking issues and that a smoking schedule had been implemented because R46 had wanted to go outside to smoke frequently and needed supervision because of elopement risk. DON stated the posting of the smoking schedule in a public area was a dignity issue. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies and procedures are reviewed and that staff training is conducted to assure residents have personal privacy during cares and that personal information regarding the resident is kept confidential and not posted for everyone to see. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21855		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area	21880		

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21880	Continued From page 64 nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances related to answering of the call lights for 6 of the 43 residents (R12, R2, R31, R53, R58, R28) who resided in the facility who expressed concern with call lights being answered. Findings include:	21880		

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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
21880	Continued From page 65 R12 stated, during an initial interview on 3/10/14, at 5:00 p.m., "I think they need better training in respect and dignity which I consider to be abusive here." When asked to further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, Yeh, what do you want? You should be able to do it yourself! R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 is not confident staff are passing on the information. Review of R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact. The resident council meeting minutes were reviewed and documentation included: (1) 3/6/14, several concerns regarding call lights were brought up such as R12 expressing staff coming into the room, whip off the call light and then leave and don't come back. R2 said, You have your call light on, they come in	21880		

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21880	Continued From page 66 and shut it off and say they will be back, they have someone else to take care of, and this happens more than once, I can have my call light on for a half hour to an hour. R31 said, call lights are generally worse during the evening. R58 was concerned about having to wait on the toilet so long. (2) 2/6/14, concerns were expressed regarding meal times and call lights continue to be an issue according to R2, R12 and R31. (3) 1/2/14, R31 When asked about the call light response time R31 expressed, will they ever be answered, so few,(two) people working, takes 40 minutes. Meal times there is no one around to answer lights. R53 agreed and commented Yes, takes half an hour. R13 expressed Staff needs to slow down, they want to throw you together and get out of there, some cares require more time (4) 12/5/13, R53 commented it took half an hour to forty five mnutes to answer the call light. R28 referred to issues with call lights after 2:00 p.m. R12 referred to a resident who was yelling out for the bell, she didn't have her call light near her. R31 said half the time the CNA (certified nursing assistants) are not reporting my request to the TMA (trained medication aide). Documentation was lacking to indicate the concerns recommendations expressed during the resident council meetings had been acted upon and discussed with the residents to assure the grievances had been remedied.	21880		

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21880	Continued From page 67 During interview on 3/13/14, at 9:15 a.m. with the activity director (AD) it was confirmed that residents concerns expressed at resident council meetings are to be documented on a grievance form by the department involved. Call lights would be the director of nursing (DON)responsibility although all staff were responsible to answer resident call lights. The AD passes the meeting minutes on to the department heads and they are to process a grievance form. The DON had attended the December and January resident council meetings and informed residents audits were being conducted of the resident call light response times, and that a memo was posted to staff. The DON did not attend the February and March resident council meetings but answered the resident concerns of the call lights not being answered timely by referring to the audits that were ongoing and a memo being posted to the staff regarding answering call lights. The AD verified the residents continiued to express serious concern with the answering of the call lights and were becoming increasingly frustrated because answering of the call lights has been a concern for many months. During an interview on 3/13/14, at 8:30 a.m. with R2 regarding resident council and concerns expressed at resident council, she stated, " I put my light on and they shut it off mostly on the evening shift. They are short of help all the time, they rush along and say we gotta go now, you get sick of it." R2 further expounded on concerns being brought up at resident council and stated, "It constantly continues to happen, why can they get by with this, I have incontinence, I have been told there is no one to help me. I have pooped in my pants two months ago waiting for someone to come. Now I have learned to call on the phone to the desk for help. I tell the nurses but I don't know	21880		

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21880	Continued From page 68 what is happening with my complaints." Document revoew pf R2's Brief Interview for Mental Status (BIMS) dated 1/20/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact. During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation to validate the resident specific concerns expressed were investigated and/or a follow up discussed to their satisfaction with the resident. The administrator stated, "We have missed a step in the process." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure residents grievances are listened to, acted upon and that results are reported back to the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous	21990		

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21990	Continued From page 69 maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63) in the sample who reported allegations of abuse. In addition, the facility failed to ensure these residents were protected from potential retaliation while an investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, during an initial observation and interview on 3/10/14, at 5:00 p.m., R12 stated, "I think they need better training in respect and dignity which I consider to be abusive here." When asked to further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems	21990		

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21990	Continued From page 70 but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, "Yah, what do you want? You should be able to do it yourself!" R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 stated not being confident staff are passing on the information. R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact. A review of the resident council minutes from December 2013 under the section "Old Business" read "Don't appreciate the evening CNA's (certified nursing assistant) coming in saying they are tot busy to help" This concern was addressed by R12. Upon review of the form titled "Resident/Family Grievance/Concern Form" for R12's statement read, "During resident council when asked, are you being treated with dignity and respect, she responded Not always and said was told, I have 30 patients today, don't give me any grief." R12 did not know who it was, only that it was in the evening and it was a CNA. Reported to Administrator 11/7/13. The administrator wrote on the form that she interviewed two nursing assistants and they both denied the allegation.	21990		

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21990	Continued From page 71 The facility was unable to produce any documentation, investigation or staff education regarding R12's grievance. R1's BIMS dated 2/20/13, indicated a summary score of 5 out of a possible 15 for cognitive patterns indicating severe impairment. Review of the December resident council meeting minutes, the question was asked, Do you feel you are treated with dignity and respect and R1 was quotes, "Some of them, evening doesn't help you." During an initial observation and interview on 3/11/14, at 2:09 p.m. when asked has anyone here abused you R1 stated Yes and further stated, "Verbal abuse has happened, I have been yelled at for needing help and have asked about it at the resident council." R1 is not aware of the disposition for her complaint and validated she continues to have concerns for abuse and stated, "Sometimes they get upset with me and will scold me for calling out for help." The facility was unable to produce any documentation, investigation or staff education regarding R1's grievance expressed from the resident council November 2013. R70, during an initial observation and interview on 3/11/14 ,at 1:29 p.m. when asked about abuse R70 stated, "I have heard the staff bark at residents and will say, I was just in here, what do you want." R70 said that administration has been informed and he has told "The powers that be, that people get yelled at or scolded here." R70 further expressed a feeling that residents are scolded and reprimanded for asking for things	21990		

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21990	Continued From page 72 and then he feels the residents are "Shunned!" R70 mentioned the ladies across the hall from him have been verbally abused from the staff and stated, "people are in pain here, people are afraid to ask to go to the bathroom because they will get yelled at, I have heard it and reported it." R70's BIMS dated 2/18/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact. The facility was unable to produce any grivance or concern documantation, investigation or education regarding R70's grievance. R59's documents were reviewed and upon reviewing a form titled Resident/Family Grievance/Concern dated 2/18/14, by R59 read, "Resident asked for his pills staff went off on him. Stated 'everyone always wants these pain pills. I feel like a drug rehab. Then said I should just get out the cards and let them just take them.' Resident showed his stomach and said if you had this it would hurt. She stated I've had worse problems." The Response /Internal investigation by facility staff member read, "Reviewed concerns with staff involved and did staff education regarding verbalizing frustration and respectfulness is resident infraction." When interviewed on 3/13/14, at 1:15 p.m., R59 verified the staff member was disrespectful and did not want to have anymore conversation about the situation. R59's BIMS dated 2/19/4, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact.	21990		

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21990	Continued From page 73 The facility was unable to produce any documentation, investigation or staff education regarding R59's grievance. R16 expressed a grievance during a resident council meeting November 2012, and read, "Last week in the evening he was in bed and a Chinese lady came into his room and twisted his leg. Resident could not give day or time this happened. The internal investigation in summary read, the writer called staff at home, who referred to residents legs being tangled in the sheet, moved his legs, but he refused to get up, brief was wet, aide changed him in bed by moving his knees to roll him over. R16 BIMS dated 8/25/13, indicated a summary score of 12 out of a possible 15 for cognitive patterns indicating moderate impairment. The facility was unable to produce any documentation, investigation or staff education regarding R16's grievance. R63 had a grievance concern which read, "Had a problem with [NA-Z], She was rude and abusive to me, she said, 'I shouldn't have to do this everyday,' It was her tone, terrible attitude." R63 thought the incident was at night on Sunday. R63 requested care and the staff member did nothing. The response to the grievance read, "Talked to NA-Z, she does not remember being this way, she is not rude but factual." R63 BIMS dated 11/12/13, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact.	21990		

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21990	Continued From page 74 The facility was unable to produce any documentation, investigation or staff education regarding R63's grievance. A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation from any other source regarding the protection, investigation, education or training on abuse related to the specific grievances for R12, R1, R70, R59, R16 or R63 and stated, "I don't know why they weren't reported as verbal abuse." The administrator thought the grievances were dealt with but could not produce any documentation to coincide with the resident complaints. The administrator validated the resident complaints were verbal abuse and should have been reported to the State Agency. The administrator validated the residents should have been protected pending investigation of the verbal abuse and the abuse prevention plan was not implemented for these residents. SUGGESTED METHOD OF CORRECTION:	21990		

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21990	Continued From page 75 The facility could assure that all allegations of potential abuse are thoroughly investigated and immediately reported to the state agency and that residents are protected from potential retaliation while an investigation is pending. The Administrator, director of nursing and/or designee could assure policies are reviewed, up to date, implemented and and that staff training has been completed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the	22000		

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22000	Continued From page 76 specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement established policies and procedures to protect residents who reported allegations of potential abuse, thoroughly investigate allegations of abuse and immediately report allegations of potential abuse to the facility's administrator and state agencies for 6 of 8 residents (R1, R12, R16, R59, R63, R70) in the sample who reported allegations of abuse. Findings include:	22000		

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22000	Continued From page 77 R1, R12, R16, R59, R63 and R70 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agency. . A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. with the administrator, she was unable to produce any further documentation from any other source regarding the protection, investigation, education or training on abuse related to the specific grievance for R1, R12, R16, R59, R63 or R70 and stated, "I don't know why they weren't reported as verbal abuse." The administrator thought the grievances were dealt with but cannot produce any documentation to coincide with the resident complaints. The administrator validated the resident complaints were verbal abuse and should have been reported to the State Agency. The administrator validated the residents should have been protected pending investigation of the verbal abuse and the abuse prevention plan was	22000		

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22000	Continued From page 78 not implemented for those residents. SUGGESTED METHOD OF CORRECTION: The facility could assure established policies and procedures for abuse prevention plan are implemented, enforced and that allegations of potential abuse are thoroughly investigated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		

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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
2 000	Continued From page 1	2 000	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. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 380	MN Rule 4658.0200 Subp. 2 Policies Concerning Residents; Telephones Subp. 2. Telephones. A nursing home must provide at least one non-coin-operated telephone which is accessible to residents at all times in case of emergency. A resident must have access to a telephone at a convenient location within the building for personal use. A nursing home may charge the resident for actual long distance charges that the resident incurs. This MN Requirement is not met as evidenced by:	2 380		

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2 380	Continued From page 2 Based on observation, interview and document review the facility failed to ensure privacy during telephone usage for 1 of 1 (R46) residents observed using the telephone. Findings include: R46 was not provided privacy during phone calls. During an interview on 3/10/14 at 5:11 p.m. R46 stated not allowed to use the portable telephone and felt rights were taken away. " Make me sit here as a good boy " . R46 was observed on 3/12/14 at 10:05 a.m. sitting in the hallway using the telephone in the nursing station. Three staff and three residents were within hearing distance. On 3/12/14 at 10:19 a.m. R46 stated the telephone call was to be private because it was to a health care provider. R46 stated did have a cell phone, but that the use of the cell phone cost money. On 3/12/14 between 1:00 p.m. and 3:00 p.m. R3 was observed to use the telephone at the nursing station four times. When asked, resident stated these phone calls were not private. Review of documents indicated R46 was admitted to the memory care unit on 11/5/13. The admission Minimum Data Set (MDS) dated 11/5/13 indicated the resident had a brief interview of mental status score (BIMS) of 13 or no cognitive impairment, displayed no behaviors, and was independent with all activities of daily living. A sign was posted outside the memory care unit. The sign stated, " Resident phone is not allowed on Memory Lane until further notice. Thank you."	2 380		

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2 380	Continued From page 3 During an interview on 3/13/14 at 12:10 p.m., the director of nursing verified no portable telephone was available in the memory care unit. DON stated it was her understanding that R46 would use the telephone for hours and not allow other residents to use the phone. DON verified the incident of being at the nursing station with staff in area was a privacy issue, but added the resident could use personal cell phone. During an interview with the social service designee (SSD) on 3/13/14 at 1:00 p.m., SSD verified the portable phone was not to be used in the memory care unit. SSD stated R46 was told that the nursing station phone was available for use. SSD stated R46's guardian did not want R46 to have access to the portable phone to call her. SSD stated the phone at the nursing station was not private. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies are updated and that staff are trained to assure residents have access to a telephone and have privacy during telephone usage TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 380		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A	2 540		

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2 540	Continued From page 4 nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to assess 1 of 1 residents (R46) for appropriateness of placement in the dementia/memory care unit at the time of admission. Findings include: R46 lacked an assessment for the appropriateness of placement on the locked dementia unit.	2 540		

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2 540	Continued From page 5 R46 was admitted to the locked dementia unit on 11/5/14 directly from an acute care hospital. The initial Preadmission Screening (PAS) dated 11/5/13 indicated R46 needed behavior management or instruction, was resistant to redirection, and had a history of homelessness.. During an interview on 3/10/14 at 5:06 p.m. R46 stated he was only 50 and felt this was not an appropriate placement. The care conference summary dated 11/25/13 indicated R46 had stated he did not want to be " locked up " Review of the admission Minimum Data Set (MDS) dated 11/12/13 noted R46 had a BIMS (brief interview for mental status) score of 13/15 or no cognitive impairment. The MDS noted R46 displayed no hallucinations, no delusional behaviors, no physical or verbal behaviors, displayed no rejection of care, and displayed no wandering behaviors. The care plan had a problem dated 11/6/13 of placement at the Faribault Care Center was appropriate for long term care; on the secured unit; an elopement risk; had a history of leaving facilities to look for alcohol. The care plan did not include interventions related to re-assessment for continued placement on the locked dementia unit. Review of the documentation revealed no elopement attempts had occurred since admission. During an interview on 3/10/14 at 6:30 p.m. the administrator (ADM) stated that she was not sure why R46 was in the dementia unit except because he was an elopement risk. ADM stated she did not think this was an appropriate placement.	2 540		

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2 540	Continued From page 6 During an interview on 3/13/14 at 12:10 p.m. the direct of nursing (DON) stated she believed R46 could climb out even with the locked fenced area. DON added she would like to see R46 in an age appropriate facility. During an interview on 3/13/14 at 1:00 p.m. the social service designee stated she was not able to find any social services documentation related to dementia unit placement for R46. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that upon admission, a comprehensive assessment is conducted each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. The director of nursing or designee could monitor to assure that residents are appropriately assessed to determine placement in the dementia/memory care unit at the time of admission. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan	2 560		

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2 560	Continued From page 7 required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care for 2 of 3 residents (R40, R70) identified as a fall risk, failed to develop a plan of care that included non-pharmacological interventions for 2 of 5 residents (R40, R27) reviewed for unnecessary medications. Findings include: R70 experienced three, unwitnessed falls, in his bedroom. The falls occurred on 3/5/14, at 12:53 a.m., on 3/6/14, at 6:45 p.m. and on 3/9/14 at 11:07 a.m. Review of the plan of care for R70 with an initiation date of 1/10/14, and a revision date of 1/20/14 revealed that there were no goals or interventions addressing falls or falls with fracture. R70's active diagnosis from the minimum Data Set (MDS) form dated 1/16/14, lists but is not limited to, hypertension, anxiety and muscle weakness. The MDS further indicated a history of falls with fracture 2-6 months prior to admission. The Care Area Assessment addresses falls as a risk for R70. R70's Brief Interview for Mental Status (BIMS) dated 1/16/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact.	2 560		

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2 560	Continued From page 8 When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address the resident's history of falls and did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care plan (on admission) should have addressed falls with interventions since the resident had a history of falls. R27's plan of care did not address parameters for use of an anti-anxiety medication and did not address use of non-pharmacological interventions prior to the administration of anti-anxiety medications. R27 was on multiple scheduled psychotropic medications, which were	2 560		

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2 560	Continued From page 9 not addressed on the plan of care. R27 Admitted 2/3/2014 with dx (from care plan) altered mental status, traumatic amputation of toes, sedative/hypnotic /anxiolytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal reflux, opioid type dependence abuse, dissociative identity disorder, drug-induced psychotic disorder with hallucinations, paranoid schizophrenia, A physician order dated 2/3/2014 identified R27 on Clonazepam 0.5 mg twice daily as needed for severe anxiety. The other scheduled psychoactive medications were Buspar, Elavil, Zyprexa, and Trilafon. Medication sheets dated 2/2014 and 3/2014 were reviewed. The resident used the as needed clonazepam (antianxiety medication) several times in both months. The scheduled other psychotropic medications were given as ordered. R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The care plan lacked documentation regarding the use of the as necessary anti-anxiety medication and did not address what non pharmacological interventions were to followed before giving the as needed anti anxiety medication. The clinical record also lacked documentation of non-pharmacological interventions attempted prior to the administration of as necessary antianxiety medication. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of as necessary (prn) antianxiety medication and stated that non	2 560		

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2 560	Continued From page 10	2 560		

pharmacological interventions should be attempted prior to the as needed anti anxiety medication. DON stated the care plan should have been developed to identify the use of the prn medication and the non pharmacological interventions.

R40's care plan did not address the use of as needed antianxiety medication for sleep and anxiety, monitoring, and use of non-pharmacological interventions prior to administration of the medication.

A Discharge summary from the hospital dated 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed.

R40 admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder, paralysis agitans, compression of brain, parkinson's disease, hx of alcohol use, intracerebral hemmorrhage, obstructive hydrocephalus, insomnia (on MD notes 1/29/2014)

A physician order dated 1/16/2014 identified Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety; and Lorazepam 0.5 mg (4 tabs of 2 mg.) by mouth at bedtime as needed for sleep.

R40's medication sheets were reviewed: Lorazepam (antianxiety medication) was used as necessary for sleep and/or anxiety: 1/14--9 times; 2/14- was used 23 times and in 3/14-it was used 8 times.

A sleep evaluation, dated 1/13/2014, was reviewed. It identified the resident had difficulty

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2 560	Continued From page 11 staying asleep; related to pain; did not have a history of taking sleep medications routinely prior to bedtime. An average length of nap was 1-2 hours. R40 had neurological deficits (stroke, Parkinson's disease, seizure disorder). No environmental factors contributing to resident sleeping difficulties was identified. The assessment was a collection of data but did not contain a summary or analysis of the data to determine a plan. R40's care plan with initiated date of 1/14/2014 and print out date of 2/20/2014 was reviewed. It did not address R40's sleep issues or use of as needed antianxiety medications. The care plan lacked documentation regarding what non pharmacological interventions should be attempted before giving the as needed anti anxiety medication. The clinical record also lacked documentation of non-pharmacological interventions to be attempted prior to the administration of medication. On 3/13/2014 at 11:45 a.m., a trained medical assistant (TMA)-C was interviewed regarding use of the antianxiety medication. TMA-C indicated she did not give the medication during the day and indicated R40 was given the medication at night for sleep. TMA-C stated the resident got anxious but rarely used it throughout the day because the resident was up and about. The TMA did not know if there was criteria to use prior to giving the medication. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the DON was interviewed regarding criteria for use of antianxiety medication. She stated they should	2 560		

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2 560	Continued From page 12 be using non pharmacological interventions prior to administering the medication and should also be following up for effectiveness. DON also checked for sleep monitoring for R40 and indicated it was not being done, DON said that the sleep plan for R40 was not based on sleep assessment data. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies and procedures are updated, implemented, that staff are trained and that monitoring is done to assure resident care plans are developed for residents at risk for falls and that non-pharmacological interventions are addressed, attempted and evaluated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the care plan was followed for 1 of 3 residents (R25) observed with urinary incontinence and 1 of 3 residents (R4) who required assistance with hearing aides.	2 565		

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2 565	Continued From page 13 Findings include: R25 did not receive incontinence care in accordance with the plan of care. During three observations incontinence care exceeded the 2 hours as noted in the care plan. The care plan printed 2/13/14 was reviewed. The care plan had a focus of, "staff assist with toileting" and directed staff to offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 pm to 7:30 p.m.R25 was observed to be lying on his back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/12/14 R25 was observed from 10:25 a.m. to 1:30 p.m. R25 was not observed to be provided continence cares for 3 hours. Nursing assistant (NA)-J stated she had last repositioned and assisted R25 at 10:00 a.m. or a total of 3.5 hours. R25 was observed on 3/12/13 at 12:00 p.m. to 1:30 p.m. At 1:30 p.m. R25 received incontinence care (by observation 1.5 hours) NA-J stated she had last provided cares to R25 at 10:00 a.m. (a total of 3.5 hours) On 3/13/14 R25 was observed from 7:09 a.m. to 8:58 a.m. and no incontinence cares were provided. NA-C stated she had worked all night and had last changed and repositioned R25 at 5:30 a.m. (greater than 3.5 hours). The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated she would expect the care plan to be followed. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not	2 565		

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2 565	Continued From page 14 been contacted by staff related to R25 refusing to receive incontinence cares. R4 did not receive assistance with hearing aides and batteries according to the plan of care. R4's plan of care dated 12/3/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide or why the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m. R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing	2 565		

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2 565	Continued From page 15 aide was missing. About 1:00 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. On 3/13/14 at 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide last week. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that care plans are up to date, implemented, staff trained and staff monitored to assure the care plans are being followed. TIME PERIOD FOR 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.	2 830		

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2 830	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the necessary care and services were provided, based on assessment, development of a care plan, and monitoring related to pain management for 3 of 3 residents (R39, R46, R29) who were reviewed for pain and for 1 resident (R25) who was reviewed for positioning issues. Findings include: R39 was experiencing migraine headache pain and was not comprehensively assessed for pain to develop effective non pharmacological interventions to minimize pain, develop criteria to identify which as needed pain medication was to be used, document effectiveness of as necessary pain medication when administered. On 3/10/2014 at 6:30 p.m., R39 was looking for a nurse for pain medication. R39 was standing in the bedroom doorway with the call light on. The nurse shut the light off and told the resident she would get some or check on the medication. At 6:49 p.m., the resident was sitting in the bedroom in the chair and the resident indicated had a migraine and would rather not interview at that time but maybe tomorrow. At 7:00 p.m. a trained medical assistant (TMA)-C went down the hall with the medication cart but didn't stop to give R39 the requested pain medication for the migraine. At 7:10 p.m., TMA-C was interviewed and stated she was just told about the Tylenol request (40 minutes after the resident requested	2 830		

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2 830	Continued From page 17 it), as she was on break, and she was going to ask R39 what the pain medication was for and she would check and see if the resident could have it. At 7:15 p.m., TMA-C came back and said the last time the resident had the Tylenol was at 1:45 p.m. and couldn't have it because received it every 6 hours. R39 was suppose to have oxygen on continuously but wouldn't do it. The TMA indicated the resident had to wait til 7:45 p.m. then could have the Tylenol ES 500 mg 2 tabs. The TMA stated they are trying to figure out why R39 was getting the migraines and requested pain medication every night at this time. Non pharmacological interventions were not offered or attempted. On 3/11/2014 at 8:00 a.m., R39 was observed sitting in the dining room and stated didn't take bath today and was short of breath. At 10:00 a.m., was observed up and about without oxygen on and then sitting in the lobby without oxygen on. At 11:50 a.m., was observed resting in bed with the lights off. At 1:20 p.m. was in bed resting and requesting a pain medication for headache. Non pharmacological interventions were not offered or attempted. On 3/12/2014 at 7:45 a.m., R39 up and sitting on edge of bed. At 1:20 p.m. in lobby, looking out the window, and stated feeling better today, and had Tylenol for a headache. At 3:20 p.m., R39 was in bed in darkened room resting. On 3/13/2014 at 8:00 a.m., R39 was out of room and at 9:00 a.m. was in room laying on the bed resting. At 11:46 a.m., the resident was up walking back from being outside and would not respond when spoken to. R39 was readmitted to the facility on 6/12/2013	2 830		

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2 830	Continued From page 18 with diagnosis which was listed in the medical diagnoses on the computer and included: chronic obstructive pulmonary disease, hepatitis C carrier, cardiac disease, esophageal reflux, nondependent cocaine abuse, drug-induced persisting dementia, and hypertension. A quarterly Minimum Data Set (MDS) dated 9/20/2013 identified the resident with moderate cognitive impairment, on a pain medication regime, received as necessary pain medications, and occasional pain affected activities and sleep. The intensity of the pain was rated as 8. A significant change MDS dated 2/7/2014, identified the resident's cognitive status as moderate , no scheduled pain regime; as necessary pain medication offered; pain was present, almost constant, but didn't affect sleep or activities. The intensity of the pain was rated at 7. Physician notes dated 2/26/2014 were reviewed. The resident was identified with chronic tension type headache, and was on Depakote medication which was increased. A Neurology consult was recommended. (according to staff appointment is scheduled for 4/2/2014). 1/29/2014, the resident had chronic tension type headache and Ibuprofen every 6 hours was started and Depakote medication. No improvement with tramadol medication, minimal improvement with Tylenol, some improvement with morphine but daily use noted and with ongoing pain. The tramadol and morphine medications were discontinued. A pain assessment was completed on 7/12 2013 and 12/14/2013, but the data was not analyzed to come up with a summary of the pain issues, a plan identifying criteria to be used to determine which pain medication to be given and a plan for non-pharmacological interventions to be used.	2 830		

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2 830	Continued From page 19 The resident was on 3, as necessary, pain medications. The medication sheets were reviewed for the following: For 12/2013 , R39 used Tylenol 1000 mg every bedtime; tramadol 50 mg every 6 hours as necessary for headache used (8x from 12/15-12/31) and Tylenol ES 500 mg every 6 hours as necessary for pain; for 1/2014, R39 used tramadol every 6 hours as necessary 26 times, Ibuprofen 400 mg every 6 hours as needed was used 3 x for headache, acetaminophen 1000 mg ES every 6 hours as needed used many times, and morphine sulfate every hour as needed for moderate to severe pain was used many times. For 2/2014, R39 was on Imatrex 100 mg daily as necessary. The resident used it 15 times; used the ibuprofen medication many times and the acetaminophen 1000 mg ES many times. For 3/2014, the ibuprofen and acetaminophen were given several times as necessary. None of the as needed pain medications had criteria to identify when to use the medication and which of the many as needed medications to use for the resident's pain issues. Non pharmacological interventions or effectiveness of the as needed pain medication were not consistently documented. R39's care plan with print date of 2/13/2014 indicated the following: I have frequent intermittent headaches (chronic for me). Pain interferes with my ability to sleep at times, but doesn ' t interfere with my ability to do my own ADL's. My pain may be as bad as 7/10 on a pain scale. On 10-13 my provider ordered extensive testing (CD scan of sinus, neurology follow up, sleep study) and once ordered I refused all of this. Interventions: anticipate my need for pain	2 830		

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2 830	Continued From page 20 relief and respond immediately. Evaluate the effectiveness of pain interventions, I am able to call for assistance. I prefer to have pain controlled by Topamax, melatonin, Tylenol and Ibuprofen. Use of narcotics is discouraged due to history of poly-substance abuse. monitor for side effects of pain med, prior to administering as necessary Tylenol, utilize non-pharmacological interventions such as ice for my head, relaxation techniques, document effectiveness. On 3/13/2014 at 12:30 p.m., a trained medical assistant (TMA)-C was interviewed regarding use of as needed (prn) pain medications and documentation. TMA-C stated they are to document prn pain medication on back of MAR (medication administration record) and effectiveness or follow up, but not always completed. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the director of nursing (DON) was interviewed regarding pain assessments and use of as needed pain medications. She indicated the pain assessments were data collection but an analysis of the data was not completed to determine a plan. The use of prn (as necessary) pain medication should be documented on the MAR and follow up for effectiveness should be on the MAR. The staff were to use a pain management form in front of the MAR for each resident which included all the components. When checked, the MAR's did not have the pain management forms and the DON stated the staff were not doing it. There should be criteria related to which pain medication to use and when and she could not find the criteria. The DON also stated Non pharmacological interventions should be attempted prior to the	2 830		

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2 830	Continued From page 21 medication administration. R46 lacked a comprehensive pain assessment, lacked a plan of care with non-pharmacological interventions for pain and lacked monitoring related to pain management. R46 was admitted to the facility 11/5/13. The care conference summary dated 11/25/13 indicated R46 had diagnoses that included alcohol induced persisting dementia, bipolar disorder, and traumatic brain injury. Physician orders signed 2/5/14 include ibuprofen 400 mg 1 tab by mouth three times daily as needed for pain, lidocaine 5% patch apply 1 patch and change daily on for 12-hours off for 12-hours, During an interview on 3/10/14 at 5:00 p.m. R46 stated he had pain but would not rate it. Stated he had numb feet. On 3/13/14 at 7:45 a.m. R46 was asked if he had pain. R46 stated he had ankle and foot numbness and that was where he wanted the lidocaine patch placed. R46 also stated he had back pain that he rated at a 7 out of 10. R46 stated he did not want the lidocaine patch placed on his back because it would not stay put. R46 was observed on all days of the survey 1/10/14 through 3/13/14 to transfer between surfaces, come to a stand, and walk without difficulty. The medication administration record was reviewed. As needed ibuprofen was given twice in January for complaints of back pain. The documentation of nursing observations did not document the intensity of the pain or if any non-pharmacological interventions had been attempted or if the medication had been effective.	2 830		

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2 830	Continued From page 22 The as needed ibuprofen was given 6 times during February. Nursing observations were recorded four times indicating the medication was given for mouth pain but lacked intensity of the pain or if any non-pharmacological interventions had been attempted. Three of the four observations indicated relief. Ibuprofen was given once during the first 2 weeks of March. Nursing observations did not record the medication was administered. The treatment administration record was reviewed. Pain was documented once per shift each day. The documentation indicated R46 did not experience pain The facility's pain assessment was completed on 2/5/14. The assessment indicated the resident experienced pain frequently that was rated at 4 on a scale of 00-10 (mild to severe intensity not addressed). The care area assessment (CAA) for pain dated 11/25/13 indicated the resident experienced pain at a scale rating of 6 and that the pain was almost constant. The analysis of findings indicated R46 had pain related to an ankle injury and was being managed by the physician. The CAA did not evaluate the frequency or intensity of pain, if there were any non-verbal indicators of pain, or any associated signs and symptoms related to the pain, any potential causal factor of pain, or the effectiveness of any pain management program. The plan of care printed 2/18/14 indicated a focus of pain medication with an intervention to administer medication as ordered. The plan of care did not identify where the pain was located and any non-pharmacological interventions to assist the resident to manage his pain.	2 830		

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2 830	Continued From page 23 During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated with as needed pain medications nurses were to document pain location, intensity and effectiveness. DON stated she had just updated the care plans, but that all nurses were responsible for keeping the care plans current. R29 lacked a comprehensive pain assessment and the development of a plan to manage the residents pain. R29 was observed on 03/11/2014 at 10:27 AM. R29 was slow to come to a sitting position in the bed. R29's face appeared pained. R29 stated her back hurt. R29 also stated that her mouth burned because of decayed teeth. R29 was observed during noon lunch on 3/12/14 at 12:23 p.m. R29 was eating a regular diet independently and was spitting out what she called meat because her mouth burned. R29 was admitted to the facility in 2009. R29 had diagnoses listed on the medication administration record as osteoporosis, depression, dementia, and pain. R29 had a physician's order for Acetaminophen 325 mg tablet. 2 tabs by mouth 4 times daily for pain. No as needed medication (PRN) orders were found. The physician documentation of 1/15/14 noted the resident complained of back pain intermittently and had a diagnoses of lumbago. R29 had a physician's order dated 10/12/11 for Tylenol 325 mg tablets 2 tabs four times daily. The quarterly Minimum Data Set (MDS) dated	2 830		

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2 830	Continued From page 24 1/13/14 indicated R29 had a score for brief interview for mental status (BIMS) of 6 or severe cognitive impairment. The MDS identified R29 had pain and that no non-medication interventions were used. The frequency and intensity of the pain was not noted. The care area assessments (CAA) dated 8/5/13 was reviewed. The nutritional status CAA noted "presumably the lack of concentration on the BIMS is a result of the oral pain." The pain status CAA noted : numeric rating scale for pain at a 6 and that resident indicated she had pain almost constantly. The CAA noted pain managed by Tylenol currently. The facility pain assessment dated 1/11/14 indicated denied pain, but stated she experienced pain occasionally. R29 rated her pain on a scale of 00-10 at a 3 or mild. The assessment indicated R29 would display facial expression when in pain and received scheduled Tylenol. The assessment did not indicate where the pain was located, what were potential causal factors of the pain and if an assessment for the cognitively impaired adult with pain had been conducted. The care plan printed 2/13/14 had a focus: reports moderate pain frequently related to arthritis of hips and back. Interventions: scheduled use of Tylenol. Administer medication as per MD orders and note the effectiveness. Give PRN meds for breakthrough [no PRN medications ordered] acknowledge presence of pains and discomfort. Document/report complaints and non-verbal signs of pain; The care plan lacked non-pharmacological interventions to assist R29 to manage her pain. Care plan problem focus: dental health problems as indicated by occasional oral pain. The interventions included: coordinate arrangements	2 830		

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2 830	Continued From page 25 for dental care. Monitor/document/report to MD PRN symptoms of oral pain needing attention. The care plan lacked non-pharmacological interventions to assist R29 to manage her oral pain. The director of nursing (DON) was interviewed on 3/13/14 at 12:36 p.m. DON stated she was aware of dental issues, but unaware of the resident ' s mouth burning. DON stated she was not sure the facility had a pain assessment for the cognitively impaired, but did know that pain had been an issue for R29. DON stated R29 complained of back pain last week. DON stated the care plan should be revised as necessary and that staff should follow the plan of care. R25 was not provided appropriate positioning when in the wheelchair or when in bed during meals. R25 was observed on 3/10/14 from 4:00 p.m. to 7:30 p.m. lying in bed with the head of the bed elevated. At 6:05 p.m. R25 received his meal and the head of the bed was elevated further. R25 was observed to have feet extended beyond the foot of the bed and was not positioned so that he sat in an upright position to eat safely. Licensed practical nurse (LPN)-I repositioned the resident higher in the bed by pulling the resident up without assist of 2 staff members. On 3/13/14 at 8:25 a.m. R25 was observed lying in bed with head of bed elevated and a breakfast tray had been provided to the resident. Registered nurse (RN)-A came to the resident's room to observe the resident. RN-A stated the resident was not positioned in order to eat the meal safely and left to find someone to help with assisting the resident to reposition in the bed.	2 830		

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2 830	Continued From page 26 The care area assessment for nutritional status dated 11/7/13 did not identify R25's safety with positioning and eating in bed. The care plan printed 2/13/14 identified a focus/problem of need assist with ADLs. Interventions included assist of 2 to boost up in bed dated 2/17/14, independent with eating, but did not direct the resident was to eat in bed and the safe positioning to eat in bed. On 3/11/14 at 9:30 a.m. R25 was observed sitting in the wheelchair. R25's back was not against the back of the wheelchair, R25's feet were on the floor, R25's was sitting forward in the chair so that his thighs were beyond the edge of the chair. The wheelchair cushion was beyond the front edge of the chair. When asked R25 stated he was not comfortable sitting in the chair. On 3/13/14 at 8:30 a.m. occupation therapist stated she had just provided R25 with a larger wheelchair and new cushion, but that she had not assessed R25 for wheelchair positioning. The care plan printed 2/13/14 identified a focus/problem of need staff assist with mobility. Interventions included use a wheelchair for mobility on the unit, will refuse to reposition almost every time. Explain why it has to be done and ask again kindly. If I am non-compliant it needs to be reported to nurse and if nurse cannot convince me to reposition, report to director of nursing During an interview on 3/13/14 at 11:45 a.m. the director of nursing (DON) indicated staff were expected to follow the care plan. If the resident would refuse cares, staff should then re-approach	2 830		

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2 830	Continued From page 27 the resident. DON stated she was unaware R29 had refused to be repositioned. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies are reviewd, revised as necessary, staff are trained and monitored to assure all residenst 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. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced	2 910		

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2 910	Continued From page 28 by: Based on observation, interview and document review the facility failed to ensure a comprehensive urinary incontinence assessment and provision of services for 2 of 3 (R25, R46) residents reviewed for incontinence. Findings include: R25 lacked a comprehensive incontinence assessment that included voiding patterns and lacked provision of services in accordance with the plan of care R25's quarterly Minimum Data Set (MDS) dated 1/24/14 was reviewed. The MDS identified diagnoses of dementia, depression, psychotic disorder. The MDS of 1/24/14 indicated R25 had total dependence on two staff for activities of daily living-including toileting care; did not have a toileting plan, and was always incontinent. The Urinary and Bowel Continence Risk Assessment checklist dated 2/13/14 indicated R25 had incontinence related to mental confusion and impaired mobility and therefore had functional incontinence. No analysis of data was documented. The Urinary Continence Intervention Guideline Tool dated 2/13/14 had a completed check list that identified R25 as having functional incontinence and recommended an assessment for pain, scheduling of a 3 day bladder elimination tracking to establish elimination pattern, and implementing prompted voiding. The Tool did not have an analysis of data to determine why the recommendations were noted and what the outcome of the bladder elimination tracking was. The Urinary and Bowel Continence Risk Assessment and Urinary Continence Intervention Guideline Tool did not	2 910		

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2 910	Continued From page 29 identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. A care plan was not developed based on assessments and evaluation. The care area assessment (CAA) dated 11/7/13 indicated R25 required extensive assistance for toileting and was always incontinent. The analysis of findings noted R25 was highly resistive to toileting. The CAA identified urinary urgency, diabetes, congestive heart failure and depression as contributing factors, but did not identify the type of incontinence or the voiding pattern/frequency. The CAA did not provide a plan of care based on the evaluation. The care plan printed 2/13/14 was reviewed. The care plan had a focus of "staff assist with toileting" and directed staff offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 p.m., to 7:30 p.m., R25 was observed to be lying on back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/11/14at 11:10 a.m., while visiting R25, a strong urine odor was detected. On 3/11/14 at 1:30 p.m. R25 was observed sitting in the wheelchair. A strong urine odor was detected and the crotch of R25's pants was observed to be wet. On 3/12/14, R25 was observed from 10:25 a.m. to 1:30 p.m. R25 was not observed to be provided incontinence cares for 3 hours. Nursing assistant (NA)-J stated she had last repositioned and assisted R25 at 10:00 a.m. or a total of 3.5 hours. R25 was observed on 3/12/13 at 12:00 p.m. to 1:30 p.m. At 1:30 p.m. R25 received	2 910		

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2 910	Continued From page 30 incontinence care (by observation 1.5 hours) NA-J stated she had last provided cares to R25 at 10:00 a.m. (a total of 3.5 hours) On 3/13/14 R25 was observed from 7:09 a.m. to 8:58 a.m. and no incontinence cares were provided. NA-C stated she had worked all night and had last changed and repositioned R25 at 5:30 a.m. (greater than 3.5 hours). During an interview on 3/12/13 at 1:30 p.m. NA-J stated two soaker pads were under the resident when in bed because he "wets a lot and this prevents soak through." The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated the urinary incontinence assessments were just being completed. The assessment was to include a 72 hour bowel and bladder diary to see if a pattern exists. The notations on the assessments should be included on the care plan. DON stated she would expect the care plan to be follow. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to receive incontinence cares. R46 lacked a comprehensive assessment and plan of care for incontinence. R46 was observed on 3/10/14 at 4:10 p.m. A strong urine smell was noted. Licensed practical nurse (LPN)-I stated he also noticed the odor but was unsure if the odor was from R46 or another resident. LPN-I stated R46 did not like to get cleaned up. No staff interventions related to the incontinence or odor was observed. On 3/12/14 at 10:05 a.m. and at 10:25 a.m. R46 was observed sitting by the nursing station with 3 staff	2 910		

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2 910	Continued From page 31	2 910		

members present. A strong urine smell was noted. No staff interventions related to incontinence and odor were observed. On 3/13/14 at 7:10 a.m. a strong urine odor was detected. R46 was observed to be wearing the same clothing as the previous day.

During an interview on 3/13/14 at 7:50 a.m. nursing assistant (NA)-C verified a strong urine odor, when near F46. NA-C stated R46 was to get a shower twice a week. NA-C was not observed to intervene.

R46 was admitted 11/5/13. The Care Conference Summary dated 11/25/13 identified diagnoses of alcohol-induced persisting dementia, bipolar disorder, and traumatic brain injury.

The admission Minimum Data Set (MDS) dated 11/12/13 and the quarterly MDS dated 1-12-14 both identified R46 as having a BIMS score (brief interview for mental status) of 13 or no cognitive impairment and to always be continent.

The treatment record for November and December documented R46 was to get a shower every other day due to incontinence but documented the resident frequently refused or was not given the opportunity. The Care Conference Summary dated 11/25/13 noted resident "will uninate [sp] in pants and refuse to change."

On 3/4/14 the facility completed Urinary and Bowel Continence Risk Assessment. The checklist identified impaired bladder emptying without documentation of a post void residual or that a physician exam had been completed, identified nocturia, and determined the resident demonstrated characteristics of overflow

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2 910	Continued From page 32 incontinence and characteristics of over active bladder/urge incontinence. The assessment did not identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. The assessments did not provide a plan of care based on the evaluation. No CAA was found or provided for urinary incontinence. Review of the care plan dated 2/18/14 did not reveal a plan/interventions to assist R46 to manage incontinence. The care plan identified the resident as independent with activities of daily living. The care plan also directed if the resident refused cares, the director of nursing was to be notified. The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated the urinary incontinence assessments were just being completed. The assessment was to include a 72 hour bowel and bladder diary to see if a pattern exists. DON stated she had not been notified of refusal of cares. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are current, that staff are trained and monitored to assure each resident is assessed for toileting needs and that a continuous program of bladder management is implemented and evaluated to reduce incontinence and that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. TIME PERIOD FOR CORRECTION: Twenty One	2 910		

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2 910	Continued From page 33 (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provision of grooming for 1 of 1 resident (R25) observed who required assistance with grooming. Findings include: R25 lacked personal grooming to remove facial hair. Review of the quarterly Minimum Data Set (MDS) dated 1/24/14 identified diagnoses of diabetes, dementia, depression, psychotic disorder. The MDS indicated a total dependence of two staff for activities of daily living. R25 was observed throughout the survey of 3/10/14 through 3/13/14. On 3/11/14 at 9:30 a.m. R25 was noted to be unshaven. On 3/12/14 at 10:25 a.m. R25 was noted to be unshaven. On 3/13/14 at 9:30 a.m., R25 was again observed to be unshaven. R25 was interviewed on 3/11/14 at 8:38 a.m. R25	2 920		

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2 920	Continued From page 34 stated that staff would only shave him every other day and had not shaved him this day. The care plan printed 2/13/14 identified a focus of behavior problems. Interventions directed if resistive to cares staff should have a nurse determine the option that is least detrimental; leave and re-approach later if continued to be resistive. The care plan identified a focus of resistive to care with interventions that directed if resist ADLs, reassure, leave and return 5-10 minutes later and try again. The care plan identified a focus needs assist with ADL's and interventions for grooming that directed staff need assist of 1 staff and encourage participation to comb own hair and brush teeth. The interventions did not provide staff with directions related to shaving. During an interview on 3/12/14 at 1:30 p.m. nursing assistant (NA)-J and trained medication aid (TMA)-E stated R25 was last shaved on Friday and that R25 did not always agree to be shaven. The director of nursing (DON) was interviewed on 3/13/14 at 11:45 a.m. DON stated she would expect shaving to be included in the care plan and for the care plan to be followed. If the resident refused cares, she would expect staff to re-approach for cares. DON stated she had not been contacted by staff related to R25 refusing to be shaved. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming,	2 920		

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2 920	Continued From page 35 and personal and oral hygiene. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the provision of thickened liquids as ordered by the physician for 1 of 1 resident (R29) reviewed with thickened liquids. Findings include: R29 was not provided thickened liquids during meals. R29 was admitted to the facility in 2011 and had diagnoses that included diabetes, Alzheimer's, depression, according to the physician orders signed 1/31/14. R29 was observed on 3/12/14 at 12:20 p.m. eating lunch independently. R29 had been	2 965		

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2 965	Continued From page 36 served a regular diet with regular liquids. On the tray were a glass of water, a glass of juice and a cup of tea. At 12:30 p.m. trained medication aide (TMA)-E placed a spoon into each glass and stated the fluids were of thin consistency. TMA-E stated she had not observed R29 to cough while eating. R29 was observed during the morning meal on 3/13/14 at 8:15 a.m. R29 was served a regular diet and thin liquids (orange juice, prune juice, milk, water.) TMA-F stated the liquids were thin. Nursing assistant (NA)-C stated R29 had never had thickened liquids since NA-C had started working in the facility a year ago. TMA-F verified on the medication administration record R29's liquids were to be nectar thick and proceeded to use thickener. The physician orders dated 10/26/13, 11/27/13, 12/31/13, 2/5/14, 3/12/14 all ordered Liberal ADA/mechanical soft with nectar thick liquids. Ok for thin milk on cereal. On 2/12/13 the speech therapist recommended nectar thick liquids. The tray card on the meal tray identified the resident was to receive nectar thick liquids. The care area assessment (CAA) dated 8/5/13 did not identify type of diet R29 was to receive. The quarterly Minimum Data Set (MDS) dated 1/13/14 indicated R29 was able to eat with limited assist of one staff, had no swallowing disorder, was on a therapeutic diet, and did not have speech therapy. The dietitian notes of 3/12/14 noted R29 was to receive a liberal ADA diet with nectar thick liquids. Review of the care plan identified a problem initiated 6/7/11 and revised on 10/11/13 that stated R29 had a swallowing problem related to difficulty with regular food. Coughing or choking during meals or swallowing medication.	2 965		

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2 965	Continued From page 37 Interventions dated 4/20/13 indicated diet to be followed as prescribed: liberal diabetic, mechanical soft textures with thin liquids. During an interview on 3/13/14 at 8:33 a.m. the administrator stated she was aware the liquids were to be thickened and had not been. During an interview on 3/13/14 at 1:00 p.m. cook-C stated she was unaware of the need for the thickened liquid until today when she received a note from licensed practical nurse (LPN)-J that the diet order was changed to thin liquids. LPN-J was interview 3/14/14 at 1:10 p.m. and stated that since last August when LPN-J started working in the facility, R29 had not received thickened liquids. SUGGESTED METHOD OF CORRECTION: The director of nursing could review policies, train staff and monitor staff to ensure the provision of thickened liquids as ordered by the physician are provided to residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 965		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		

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21390	Continued From page 38 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during dressing change for 1of 2 residents (R45) with a gastric tube dressing and tube feeding, failed to ensure isolation precautions were adhered to for 1 of 1 residents (R48) with isolation precautions and failed to assure 1 of 1 residents (R10)Nebulizer equipment was sanitized between use. Findings include: R45 had a gastric feeding tube and during dressing change, infection control practices were not implemented to prevent spread of infection.	21390		

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R45 was readmitted on 12/26/2013 with diagnoses (listed from the care plan) that included: encephalopathy, dysphagia, history of traumatic brain injury, post traumatic seizures, dementia with behavioral disturbances, episodic mood disorder, schizophrenia, and CVA (stroke).

During observations, on 3/11/2014 at 9:20 a.m., LPN-C went into R45's room to do a dressing change around the gastric tube. LPN-C gloved and removed the dressing which had a tiny bit of blood tinged drainage on it. Without changing gloves, the LPN opened drawers and touched packaged supplies, the resident's chair, door handles to the closet, a blood pressure cuff, bag containing oral toothettes, and a mat which was leaning against the closet. Keeping the same gloves on, the LPN took water from a pitcher and use a Q-tip to clean around the gastric tube stoma area. Slight pinkish drainage was noted on the Q-tip. LPN-C then touched the medication and feeding syringe and tube extension. LPN-C snapped the extension on the gastric tube and checked for patency using a stethoscope. When attempting to administer water, the water did not go in. LPN-C had to use the stethoscope again to listen for patency. At that point, the LPN-C was wearing the same soiled gloves and touched the resident's skin, the stethoscope and the tubing. She disconnected the extension tube and took it into the bathroom to rinse it out. The LPN -C did not change the soiled gloves and continued to reapply the extension tube to the gastric tube. Without changing the soiled gloves, the LPN-C continued to administer water and medication through the tube using the same syringe. After LPN-C was finished with the medication task, she did not have gauze to put around the stoma area. She removed the soiled gloves and went out to the medication cart to find the gauze. The LPN

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21390	Continued From page 40 gloved and put the gauze around the stoma. On 3/12/2014 at 11:00 a.m., the director of nursing (DON) was interviewed regarding lack of infection control procedures used with R45's dressing change to the gastric tube site. The DON stated the nurse's should be following standard precautions and also the facility policy for dressing changes that are not sterile. A policy was requested and provided by the facility. A policy for Dressing-Non-sterile Treatment revised 6/2013 was reviewed. It identified: "6. Place supplies on clean field. 7. Wash hands. 8. Apply clean gloves. 11. Remove soiled dressing and dispose of in bag. Remove gloves. Wash hands. 12. Apply clean gloves. 13. Clean wound per physician orders. Cleanse wound from center to outer boarders using a circular motion (area of most contamination to area of least). Ensure you do not touch other skin surfaces, furniture, bedding, etc., and return to wound bed as this will contaminate the wound bed. 14. Dispose of cleaning supplies in bag. 15. Remove gloves and wash hands. 16. Apply clean gloves. 17. Apply dressing as ordered." R48 had respiratory methicillin resistant staph aureous (MRSA) with a tracheostomy and infection control precautions were not consistently implemented. A physician note dated 3/5/2014 identified history of present illness: Respiratory: Patient with chronic tracheostomy and with increased cough shortness of breath and sputum culture showed MRSA and Pseudomonas and started on IV	21390		

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21390	Continued From page 41 antibiotics. Treatment for bronchopneumonia: possible pneumonia with sputum with pseudomonas and MRSA. On 3/10/2014 at 5:20 p.m. R48's room door was closed. A note to check at nurse's station was on the wall at the doorway. A plastic cupboard at the doorway contained gowns, gloves, masks, red bags, and a blood pressure cuff and thermometer. On 3/11/2014 at 8:00 a.m. R48 was observed ambulating in the hall with a walker and had a mask over a trach site and then stood at the medication cart waiting for medications. At 9:00 a.m., R48 was observed to come out of the room with the mask off the trach site. A licensed practical nurse (LPN)-C puts a mask over the trach site and tells the resident it needed to be on because of an infection the resident had. LPN-C stated the resident was on precautions related to respiratory methicillin resistant staph aureos (mrsa). LPN-C gloved and put a mask on and stated she didn't gown because the resident didn't spit. She wore a mask because of droplets in the air and coughing from the trach and R48 was not good about leaving a mask on. The LPN went into the resident room and assisted the resident out of the bathroom. The resident took the mask off the trach and sat on the edge of the bed. At 9:47 a.m., R48 came out of the room with a mask over the trach and stands by the medication cart. The LPN touched the resident's walker to redirect the resident away from the cart and then without cleansing her hands continued to set up medications. At 10:00 a.m., R48 removed the mask and threw it on top of a waste basket on the cart but it just laid on top of the basket. LPN-C applied a new mask and	21390		

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continued to set up the medication without washing her hands.
At 2:05 p.., R48 came ambulating out from room to nurse's desk without a mask over the trach. The resident's room is the second door down the hall and so the resident walks a distance to get to the nurse's station. The nurse saw the resident and got a mask.

On 3/11/2014 at 10:00 a.m., R48 walked into the nursing station and stood over NA-K who tried to redirect the resident back to his room since the tracheostomy was not covered.

On 3/12/2014 at 7:45 a.m., R48 was observed up with walker at nurse's desk, however, had a mask on trach site. At 9:45 a.m., R48 was observed ambulating in the hallway with walker and no mask on. LPN-C tried to redirect the resident, touched the walker, and continued to set up medication, without washing hands, while the resident stood there. LPN-C indicated she didn't wear a gown in the room but just a mask and gloves because the resident didn't cough or spray and she didn't even during suctioning because everything goes up the tube and there is no spray there. At 10:00 a.m., LPN-C entered the room with mask and gloves on. There were no gowns in the container outside the room. The resident is already laying in bed. The LPN pulled on the incontinent cloth pad under the resident, moved the resident ' s feet, touched the linens and then the resident's forehead. With her gloves still on, she raised the bed with the controls. Without changing gloves, LPN-C removed the mask over the resident's trach, touched the dressing around the trach, and then removed the inner cannula and disposed of it in the wastebasket. Then removed the soiled gloves (had mucous on them) and regloved. The LPN Opened up the new

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package of cannula and put it in the trach site. With the gloves still on, the LPN administered the neb medication into the neb mask and extension and started it up and placed it on the resident over the trach. She got out a new feeding syringe and dated it, poured water into a pitcher, touched the resident clothing and dressing to the feeding tube. Went into her pocket for something and then removed the tip of the syringe and put an extension on the feeding tube. She put the syringe in the tubing with air in it and takes a stethoscope to check for placement. The LPN retrieved 2 cans of feeding formula out of the box in the room, while holding the feeding syringe without a cap on it next to her clothing. Without changing gloves, or the feeding syringe, the LPN puts the syringe into the extension tube to the tube feeding and gives the resident the medications and water flushes. After finishing , the LPN then unhooked the extention tube and recapped the syringe tube. Without changing her gloves, she touched around the stoma skin site of the tube feeding and then readjusted the nebulizer mask and parts, then put on a clean dressing to the tube site. The bathroom did not have any soap in the dispenser. But the LPN indicated she had sanitizer on her medication cart. When checked, the sanitizer was not on the cart and another staff had to retrieve some. At 3:15 p.m., R48 had been out at nurse's desk several times, however the resident did have mask on over the trach site.

On 3/12/2014 at 10:30 a.m., LPN-C verified she did not change her gloves appropriately throughout the procedures for R48.

On 3/12/2014 at 12:45 p.m., LPN-J went into R48's room without putting on a mask and gloves or gown. She laid a cloth chux on the resident's

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21390	Continued From page 44 bed and straightened it out touching linens. The resident had a mask over the trach but was noted to cough. When the LPN-J went into the bathroom to wash her hands she noted there was no soap in the dispenser. She went to the soiled utility room to wash her hands. It was 2 doors down from the resident's room. LPN-J told the housekeeper the resident's bathroom needed soap and the housekeeper went in and filled the dispenser. On 3/12/2014 at 12:49 p.m., a nurse aide (NA)/medical records (MR) (NA)-K/(MR)-K walked into R48's room without a mask, or gloves or gown on. The aide directed the resident into the room and touched the walker and the resident on the back. The resident wanted assistance to get into bed. The aide walked out without washing her hands. NA-F put her gloves on and mask and went in to assist the resident into bed. NA-F was interviewed about the resident and use of a mask over the trach area. She indicated the nurse aides put a mask over the trach when they do cares on the resident . If they see R48 come out of the room, they redirect the resident back to the room and encourage the resident to put a mask on or they do it for the resident. The resident was independent with toileting and washing own hands. On 3/13/2014 at 6:45 a.m. , LPN-B was observed in R48's room suctioning the resident. The resident was coughing. LPN-B did not wear a mask but had gloves on. No gowns were available in the cabinet outside the resident's door. At 8:30 a.m., R48 came out to nurse's desk without a mask on and 2 staff (NA-K, LPN-J) walk by the resident for several minutes before redirecting the resident to get a mask on.	21390		

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21390	Continued From page 45 On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. R48 was placed on precautions because the resident had a positive culture for MRSA respiratory. Interviewed the DON on observations of poor handwashing and glove exchange, lack of soap in the bathroom, lack of gowns in the cupboard and also discussed observations of resident leaving room without a mask and sometimes being directed and other times not. The DON indicated the staff should be following the precautions because the resident was positive for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precaution sign was placed at the doorway of the resident's room. On 3/13/2013 at 2:00 p.m., R48 walked into the nursing station and stood over RN-A for several minutes until RN-A was able to direct R48 back to his room as the tracheostomy was not covered. On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was interviewed. and verified R48 had a problem coming out to the desk area and in the hallways without keeping the trach area covered as directed by facility protocol. On 3/13/2014 at 1:30 p.m., the DON was again interviewed regarding infection control procedures. She stated "[R48], we are unable to keep him in isolation so he is in what we call precaution, but he does not follow through with that either. We are constantly taking him to his	21390		

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21390	Continued From page 46 room and reapplying the masks to cover the trach (tracheostomy)." NEBULIZER EQUIPMENT WAS NOT SANITIZED BETWEEN USE: R10 s nebulizer system was observed on 3/12/14 at 10:15 a.m. to be located on his bed side stand. The nebulizer cup and tubing was attached to the machine. The nebulizer cup where the medication is placed was coated with moisture drops on the inside of the cup. Licensed practical nurse (LPN)-B was interviewed on 3/12/14 at 10:15 a.m. and said that she had set up and given R10 his nebulizer medication treatment at 8:00 a.m. However, LPN-B had not cleaned the equipment following the inhalation treatment to prevent bacterial and/or fungus growth as outlined in the facility policy. Again on 3/13/14 at 1/17 p.m. R10's nebulizer was noted to be fully connected and this time there was a white film coating the entire inside of the nebulizer cup. On asking R10 about the use and care of the nebulizer equipment at this time R10 said, "They [referring to facility staff] don't ever clean it." R10 said that he had used the nebulizer equipment earlier in the day and no one has touched it since then. On 3/13/14 at 2:00 p.m. trained medication assistant (TMA)-A was asked about the use and cleaning of R10's nebulizer equipment following the inhalation treatment. TMA-A said that the equipment is to be taken apart and the cup is to be rinsed in water and the equipment is to air dry.	21390		

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21390	Continued From page 47 However, this had not been done following R10's inhalation treatment on 3/12/14 8:00 a.m. dose nor on 3/13/14 after 8:00 a.m. dose. The director of nursing was made aware of lack of following the facility policy on the care of the nebulizer equipment on 3/13/14 at 2:47 p.m. and she was also asked for the policy in regards to the nebulizer inhalation procedure. Facility policy Desert Health Group Small Volume Nebulizer Procedures, revised date 06/2013 read, "11. Administer therapy until the medication is depleted (about 10-15 minutes)." and "13. Disassemble device and rinse the mouthpiece and nebulizer cup with water and dry. Store unit per facility policy. Dispose of equipment per facility policy." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are current, that staff are trained and monitored to assure procedures are implemented to prevent the spread of infection when caring for residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the	21510		

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21510	Continued From page 48 required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide rehabilitative services as necessary for 1 of 1 resident (R46) reviewed. Findings include: R46 lacked a referral for rehabilitation services. R46 was admitted on 11/5/13 from an acute care hospital to the facility's locked dementia unit. R46's diagnoses listed on the preadmission screening dated 11/5/13 at Karsakoff dementia (alcohol induced dementia) and bipolar disease. The care plan printed 2/18/14 identified R46's diagnoses as alcohol induced dementia, bipolar disorder, alcohol dependence, drunkenness, acute alcoholic hepatitis. The Admission Minimum Data Set (MDS) dated 11/12/13 and the quarterly MDS dated 1/12/14 indicated R46 had a brief interview for mental status (BIMS) score of 13/15 or no cognitive impairment, displayed no behaviors, was independent with activities of independent living. During an interview on 3/10/14 at 5:13 p.m. R46 stated was admitted with a diagnosis of alcohol abuse and had not been involved in a treatment program. R46 stated he had investigated outpatient services, found some available in this community, but had not been provided access to them. R46 stated he would be willing to do outpatient or inpatient treatment. The care conference summary dated 11/25/13	21510		

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21510	Continued From page 49 noted, "Resident would like to be in a treatment facility or a facility where people are younger." The care plan printed 2/18/14 was reviewed. The resident's history with alcohol and request for treatment was not noted. During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she thought social services was working on the treatment issues. The social service designee (SSD) was interviewed on 3/13/14 at 12:57 p.m. SSD stated R46 had discussed with her the request of treatment as outpatient or inpatient. SSD stated she had contacted the guardian. SSD stated the guardian did not want R46 to go to treatment because guardian was afraid R46 would not be able to return to the nursing home. SSD stated she had also discussed treatment with the county case manager and that he had said the facility needed to get the guardian on board. SSD stated the management team stated the facility would not hold the bed for return following the 90-day inpatient treatment program so SSD did not know if a readmission bed would be available. SSD stated she had not investigated further for outpatient treatment. SSD stated she was unable to find any social services documentation from previous social worker related to treatment programs. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could monitor to assure that residents are assessed and referred to appropriate rehab services as necessary. TIME PERIOD FOR CORRECTION: Twenty One	21510		

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21510	Continued From page 50 (21) days.	21510		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop parameters for use and failed to monitor the effectiveness of as needed psycho-active medications for 2 of 5 residents (R27, R40) reviewed for unnecessary medications. Findings include:	21540		

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21540	Continued From page 51 R27 was on an anti-anxiety medication without parameters for use, documentation of effectiveness when used, and without use of non-pharmacological interventions; and was on multiple scheduled psychotropic medications without adequate monitoring . R27 was admitted to the facility 2/3/2014 with dx (from care plan) altered mental status, traumatic amputation of toes, sedative/hypnotic /anxiolytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal reflux, opioid type dependence abuse, dissociative identity disorder, drug-induced psychotic disorder with hallucinations, paranoid schizophrenia, A physician order dated 2/3/2014 identified R27 on Clonazepam 0.5 mg twice daily as needed for severe anxiety. The other scheduled psychoactive medications were Buspar, Elavil, Zyprexa, and Trilafon. Medication sheets dated 2/2014 and 3/2014 were reviewed. The resident used the as needed clonazepam (antianxiety medication) several times in both months. The scheduled other psychotropic medications were given as ordered. The target behaviors that were identified to be monitored included mood indicators, behavior indicators, hearing voices not there, seeing objects not there, agitation-not responding to direction, and pacing. These behaviors were documented on every shift daily. However, an analysis of the behaviors was not compiled of the data to identify effectiveness of the use of the as needed antianxiety medication and other multiple psychotropic medications (Buspar, Zyprexa, Elavil, Trilafon).	21540		

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21540	Continued From page 52 R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The use of the as necessary and scheduled psychotropic medications with interventions was not addressed. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of prn antianxiety medication. DON stated staff should be documenting in the MAR and follow up for effectiveness. They are to attempt non pharmacological interventions prior to the prn use. The documentation was not evident in the MAR or record and the DON verified that. On 3/13/2014 at 12:50 p.m., and 3:00 p.m., the DON was interviewed regarding a summary/analysis of the behavioral data to identify effectiveness of the scheduled medication and use of the as needed antianxiety medication. She indicated no analysis was done of the behavioral data. No criteria for the use of the as needed medication was provided. R40 used as needed antianxiety medication for sleep and anxiety without criteria for use, monitoring of effectiveness and lack of use of non-pharmacological interventions prior to administration. A Discharge summary from the hospital dated 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed. Admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder,paralysis agitans, compression of brain, parkinson's disease, hx of	21540		

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21540	Continued From page 53 alcohol use, intracerebral hemmorrhage, obstructive hydrocephalus, insomnia. (on MD notes 1/29/2014) A physician order dated 1/16/2014 identified Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety; and Lorazepam 0.5 mg (4 tabs of 2 mg.) by mouth at bedtime as needed for sleep. R40's following medication sheets were reviewed: Lorazepam (antianxiety medication) was used as necessary for sleep and/or anxiety: 1/14--9 times; 2/14- was used 23 times and in 3/14-it was used 8 times. A sleep evaluation dated 1/13/2014 was reviewed. It identified the resident had difficulty staying asleep; related to pain; did not have a history of taking sleep medications routinely prior to bedtime. An average length of nap was 1-2 hours. R40 had neurological deficits (stroke, Parkinson's disease, seizure disorder). No environmental factors contributing to resident sleeping difficulties was identified. The assessment was a collection of data but did not contain a summary or analysis of the data to determine a plan. R40's care plan with initiated date of 1/14/2014 and print out date of 2/20/2014 was reviewed. It did not address R40's sleep issues or use of as needed antianxiety medications with interventions. On 3/13/2014 at 11:45 a.m., a trained medical assistant (TMA)-C was interviewed regarding use of the antianxiety medication. TMA-C indicated	21540		

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21540	Continued From page 54 she did not give the medication during the day and indicated R40 was given the medication at night for sleep. The resident got anxious but rarely used it throughout the day because the resident was up and about. The TMA did not know if there was criteria to use prior to giving the medication. On 3/13/2014 at 12:50 p.m. and 1:05 p.m., the DON was interviewed regarding criteria for use of antianxiety medication. DON stated they should be using non pharmacological interventions prior to administering the medication and should be following up also for effectiveness. The DON indicated she just did an education on that on 2/17/2014. She also checked for R40 re: sleep monitoring and indicated it was not being done. DON verified they did not analyze the sleep assessment data to come up with a plan. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings,	21685		

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21685	Continued From page 55 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 and interview the facility failed to keep kitchen equipment and the kitchen environment clean and sanitary, also failed to keep the physical environment free from foul odors. Finding include: During the kitchen tour with Cook-A and Cook-B on 3/10/14 at 1:45 p.m. the following was observed: Upright freezers and refrigerators located in the kitchen had a thick layer of dust covering the grill and when the grill was moved the dust covered the entire top of the pieced of equipment. The ice machine located in the dining room was observed to have the grill covered with a thick coat of dust/debris and the reusable filter was coated with white powder type debris. The floor in the kitchen had multiple food debris scattered around the perimeter of the room. The electrical cords and water tubing connected to the appliances including the coffee maker was coated with a thick layer of dust/debris. The metal emergency pull ring located near the coffee machine had long strands of dust/debris. During the environmental tour on 3/13/14 at 8:30 a.m. accompanied by the director of maintenance	21685		

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21685	Continued From page 56 and lead housekeeper. The following was observed: The bathroom in room 113 had a strong urine odor present and the toilet had been flushed and the odor continued to be present. The housekeeper said it sometimes smells and they do clean in the bathroom. However, the urine smell continues to be present. The 300 wing was observed to have resident use equipment including wheel chair, weight chair, resident lifts lined down the west side of the hallway. Also the medication cart is placed on the west side of the hallway. There were two residents who met each other going in the opposite directions and one of them had to move into an open door way to allow the other resident pass them by. With the west side of the hallway used to store resident equipment the residents who are ambulatory do not have free access to the hand rails on the west side to the hallway. On asking the maintenance director and housekeeper it was learned that they have to use the west side of the 300 wing to store resident equipment because there is no storage room in the area to keep them. It was also learned from the maintenance director and housekeeper that this practice of keeping resident equipment stored on the west hallway has been practiced for a long time. SUGGESTED METHOD OF CORRECTION: The director of nursing, director of maintenence and/or designee could assure the physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment is kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the	21685		

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21685	Continued From page 57 residents according to a written routine maintenance and repair program. TIME PERIOD FOR 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 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 ensure the use of functioning hearing aides for 1 of 2 residents (R4) observed with hearing aides. Findings include: During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide	21810		

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or why the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions.

During an observation on 3/13/14, at 11:50 a.m., R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine.

At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide last week.

R4's active diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears.

R4's Brief Interview for Mental Status (BIMS) dated 12/30/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment.

R4's plan of care dated 12/3/13, directed staff, "I

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am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." The interventions read, "I want my hearing aids left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and theft policies of the facility. I wear bilateral hearing aids. I can put them in and take them out independently. I will ask for assist if I need, especially with taking battery out." An intervention on the plan of care dated 10/25/13, read "Staff again attempted to have resident allow hearing aides kept in nurses cart for safe keeping. Resident rejected the offer. Because of history of losing hearing aides, staff will not remove anything from residents room without first assuring hearing aides are accounted for."

The consultation report from audiology dated 7/16/13, under recommendations read, "Need plan from nursing home of how future loss of hearing aids will be prevented before patient is fit with replacement. Return in 2 weeks for a hearing aide fitting." The consultation report from audiology dated 9/3/13, read "1. Continue wearing both aides daily. 2. Replacing both batteries weekly, early if needed (the left uses the size 13 or orange and right uses size 675 or blue). 3. Turn hearing aids off when not in use by opening battery doors. 4. Return in 4 months for a hearing aide recheck, sooner if there are problems." A document titled Audiology office visit and dated 10/4/13, read "The right hearing aide had a size 13 battery in it instead of the 675. The tubing was twisted on both hearing aides. The

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21810	Continued From page 60 batteries were replaced in both hearing aids. The tubing was replaced. Both hearing aides are working fine now." In review of the medication and treatment sheets for March 2014, there was no area addressing the tracking of the bilateral hearing aides. The nursing assistant assignment sheet read, "Hearing Aides." but did not designate the battery size for which ear, nor did the assignment sheet direct staff to account for the hearing aides. Attempts to call the resident family were unsuccessful to discuss the hearing aides and the medical record director (MRD) validated the family was difficult to get hold of as neither had answering machines or message capabilities. The MRD did not know if the family was aware of the right hearing aide being missing. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies, procedures are updated, implemented, evaluated, monitored and that based on individual assessments, personal care based on individual needs is provided to enable residents to achieve their highest level of physical and mental functioning TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21810		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and	21855		

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21855	Continued From page 61 personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure personal privacy during cares for 1 of 3 residents (R25) observed for incontinence and the facility failed to confidentially post personal information for 1 of 4 residents (R46) observed smoking. Findings include: R25 lacked privacy during incontinence cares. During an interview on 3/11/14 at 9:12 a.m. R25 stated staff did not pull curtains or close doors to provide privacy during cares. R25 was observed during incontinence cares provided by nursing assistant (NA)-J and trained medication aide (TMA)-E on 3/12/14 between 1:30 p.m. and 1:50 p.m. During the cares R25 was observed to urinate on the bed linens. TMA-E was observed to open the door and leave the room without pulling the privacy curtain or providing personal privacy to R25 who was lying in bed exposed. TMA-E reentered the room again. No privacy curtain was pulled and no personal privacy was provided to R25. TMA-E was interviewed at 1:50 p.m. and stated the privacy curtain should have been pulled	21855		

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21855	Continued From page 62 before she exited the room. During an interview on 3/13/14 at 11:45 a.m. the director of nursing stated privacy was an expectation of care. R46 lacked confidentiality of personal smoking information. On 3/10/14 at 5:30 p.m. a sign was observed posted in the nursing area/dining room/resident activity area that stated [R46's name in bold typing] Smoking Schedule. The sign listed the times and mount of cigarettes R46 could smoke During an interview on 3/10/14 at 5:11 p.m. R46 stated the cigarettes were locked up and felt rights were taken away. R46 was observed on 3/12/14 at 7:10 p.m., on 3/13/14 at 7:35 a.m. outside to smoke under staff supervision. Each time R46 was observed to ask staff to be able to smoke. Review of documents identified the facility completed a smoking assessment on 2/6/14 that stated the resident required supervision, had cognitive loss, and had been observed smoking in bedroom or bathroom. The facility elopement risk assessment dated 2/6/14 noted under smoking, "will jump fence if given a chance". No assessment/ analysis of data was provided. Review of the care plan printed, 2/18/14, had a focus related to smoking The interventions directed the resident required visual supervision while smoking, that cigarettes and lighter were to be locked up.	21855		

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21855	Continued From page 63 During an interview on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she was aware R46 had smoking issues and that a smoking schedule had been implemented because R46 had wanted to go outside to smoke frequently and needed supervision because of elopement risk. DON stated the posting of the smoking schedule in a public area was a dignity issue. SUGGESTED METHOD OF CORRECTION: The facility could assure that policies and procedures are reviewed and that staff training is conducted to assure residents have personal privacy during cares and that personal information regarding the resident is kept confidential and not posted for everyone to see. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21855		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area	21880		

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21880	Continued From page 64 nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances related to answering of the call lights for 6 of the 43 residents (R12, R2, R31, R53, R58, R28) who resided in the facility who expressed concern with call lights being answered. Findings include:	21880		

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21880	Continued From page 65 R12 stated, during an initial interview on 3/10/14, at 5:00 p.m., "I think they need better training in respect and dignity which I consider to be abusive here." When asked to further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, Yeh, what do you want? You should be able to do it yourself! R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 is not confident staff are passing on the information. Review of R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact. The resident council meeting minutes were reviewed and documentation included: (1) 3/6/14, several concerns regarding call lights were brought up such as R12 expressing staff coming into the room, whip off the call light and then leave and don't come back. R2 said, You have your call light on, they come in	21880		

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21880	Continued From page 66 and shut it off and say they will be back, they have someone else to take care of, and this happens more than once, I can have my call light on for a half hour to an hour. R31 said, call lights are generally worse during the evening. R58 was concerned about having to wait on the toilet so long. (2) 2/6/14, concerns were expressed regarding meal times and call lights continue to be an issue according to R2, R12 and R31. (3) 1/2/14, R31 When asked about the call light response time R31 expressed, will they ever be answered, so few,(two) people working, takes 40 minutes. Meal times there is no one around to answer lights. R53 agreed and commented Yes, takes half an hour. R13 expressed Staff needs to slow down, they want to throw you together and get out of there, some cares require more time (4) 12/5/13, R53 commented it took half an hour to forty five mnutes to answer the call light. R28 referred to issues with call lights after 2:00 p.m. R12 referred to a resident who was yelling out for the bell, she didn't have her call light near her. R31 said half the time the CNA (certified nursing assistants) are not reporting my request to the TMA (trained medication aide). Documentation was lacking to indicate the concerns recommendations expressed during the resident council meetings had been acted upon and discussed with the residents to assure the grievances had been remedied.	21880		

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FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(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
21880	Continued From page 67 During interview on 3/13/14, at 9:15 a.m. with the activity director (AD) it was confirmed that residents concerns expressed at resident council meetings are to be documented on a grievance form by the department involved. Call lights would be the director of nursing (DON)responsibility although all staff were responsible to answer resident call lights. The AD passes the meeting minutes on to the department heads and they are to process a grievance form. The DON had attended the December and January resident council meetings and informed residents audits were being conducted of the resident call light response times, and that a memo was posted to staff. The DON did not attend the February and March resident council meetings but answered the resident concerns of the call lights not being answered timely by referring to the audits that were ongoing and a memo being posted to the staff regarding answering call lights. The AD verified the residents continiued to express serious concern with the answering of the call lights and were becoming increasingly frustrated because answering of the call lights has been a concern for many months. During an interview on 3/13/14, at 8:30 a.m. with R2 regarding resident council and concerns expressed at resident council, she stated, " I put my light on and they shut it off mostly on the evening shift. They are short of help all the time, they rush along and say we gotta go now, you get sick of it." R2 further expounded on concerns being brought up at resident council and stated, "It constantly continues to happen, why can they get by with this, I have incontinence, I have been told there is no one to help me. I have pooped in my pants two months ago waiting for someone to come. Now I have learned to call on the phone to the desk for help. I tell the nurses but I don't know	21880		

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21880	Continued From page 68 what is happening with my complaints." Document revoew pf R2's Brief Interview for Mental Status (BIMS) dated 1/20/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact. During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation to validate the resident specific concerns expressed were investigated and/or a follow up discussed to their satisfaction with the resident. The administrator stated, "We have missed a step in the process." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure residents grievances are listened to, acted upon and that results are reported back to the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous	21990		

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21990	Continued From page 69 maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63) in the sample who reported allegations of abuse. In addition, the facility failed to ensure these residents were protected from potential retaliation while an investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, during an initial observation and interview on 3/10/14, at 5:00 p.m., R12 stated, "I think they need better training in respect and dignity which I consider to be abusive here." When asked to further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems	21990		

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21990	Continued From page 70	21990		

but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, "Yah, what do you want? You should be able to do it yourself!" R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 stated not being confident staff are passing on the information.

R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact.

A review of the resident council minutes from December 2013 under the section "Old Business" read "Don't appreciate the evening CNA's (certified nursing assistant) coming in saying they are tot busy to help" This concern was addressed by R12. Upon review of the form titled "Resident/Family Grievance/Concern Form" for R12's statement read, "During resident council when asked, are you being treated with dignity and respect, she responded Not always and said was told, I have 30 patients today, don't give me any grief." R12 did not know who it was, only that it was in the evening and it was a CNA. Reported to Administrator 11/7/13. The administrator wrote on the form that she interviewed two nursing assistants and they both denied the allegation.

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21990	Continued From page 71 The facility was unable to produce any documentation, investigation or staff education regarding R12's grievance. R1's BIMS dated 2/20/13, indicated a summary score of 5 out of a possible 15 for cognitive patterns indicating severe impairment. Review of the December resident council meeting minutes, the question was asked, Do you feel you are treated with dignity and respect and R1 was quotes, "Some of them, evening doesn't help you." During an initial observation and interview on 3/11/14, at 2:09 p.m. when asked has anyone here abused you R1 stated Yes and further stated, "Verbal abuse has happened, I have been yelled at for needing help and have asked about it at the resident council." R1 is not aware of the disposition for her complaint and validated she continues to have concerns for abuse and stated, "Sometimes they get upset with me and will scold me for calling out for help." The facility was unable to produce any documentation, investigation or staff education regarding R1's grievance expressed from the resident council November 2013. R70, during an initial observation and interview on 3/11/14 ,at 1:29 p.m. when asked about abuse R70 stated, "I have heard the staff bark at residents and will say, I was just in here, what do you want." R70 said that administration has been informed and he has told "The powers that be, that people get yelled at or scolded here." R70 further expressed a feeling that residents are scolded and reprimanded for asking for things	21990		

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21990	Continued From page 72 and then he feels the residents are "Shunned!" R70 mentioned the ladies across the hall from him have been verbally abused from the staff and stated, "people are in pain here, people are afraid to ask to go to the bathroom because they will get yelled at, I have heard it and reported it." R70's BIMS dated 2/18/14, indicated a summary score of 14 out of a possible 15 for cognitive patterns indicating cognitively intact. The facility was unable to produce any grivance or concern documantation, investigation or education regarding R70's grievance. R59's documents were reviewed and upon reviewing a form titled Resident/Family Grievance/Concern dated 2/18/14, by R59 read, "Resident asked for his pills staff went off on him. Stated 'everyone always wants these pain pills. I feel like a drug rehab. Then said I should just get out the cards and let them just take them.' Resident showed his stomach and said if you had this it would hurt. She stated I've had worse problems." The Response /Internal investigation by facility staff member read, "Reviewed concerns with staff involved and did staff education regarding verbalizing frustration and respectfulness is resident infraction." When interviewed on 3/13/14, at 1:15 p.m., R59 verified the staff member was disrespectful and did not want to have anymore conversation about the situation. R59's BIMS dated 2/19/4, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact.	21990		

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21990	Continued From page 73 The facility was unable to produce any documentation, investigation or staff education regarding R59's grievance. R16 expressed a grievance during a resident council meeting November 2012, and read, "Last week in the evening he was in bed and a Chinese lady came into his room and twisted his leg. Resident could not give day or time this happened. The internal investigation in summary read, the writer called staff at home, who referred to residents legs being tangled in the sheet, moved his legs, but he refused to get up, brief was wet, aide changed him in bed by moving his knees to roll him over. R16 BIMS dated 8/25/13, indicated a summary score of 12 out of a possible 15 for cognitive patterns indicating moderate impairment. The facility was unable to produce any documentation, investigation or staff education regarding R16's grievance. R63 had a grievance concern which read, "Had a problem with [NA-Z], She was rude and abusive to me, she said, 'I shouldn't have to do this everyday,' It was her tone, terrible attitude." R63 thought the incident was at night on Sunday. R63 requested care and the staff member did nothing. The response to the grievance read, "Talked to NA-Z, she does not remember being this way, she is not rude but factual." R63 BIMS dated 11/12/13, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact.	21990		

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21990	Continued From page 74 The facility was unable to produce any documentation, investigation or staff education regarding R63's grievance. A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation from any other source regarding the protection, investigation, education or training on abuse related to the specific grievances for R12, R1, R70, R59, R16 or R63 and stated, "I don't know why they weren't reported as verbal abuse." The administrator thought the grievances were dealt with but could not produce any documentation to coincide with the resident complaints. The administrator validated the resident complaints were verbal abuse and should have been reported to the State Agency. The administrator validated the residents should have been protected pending investigation of the verbal abuse and the abuse prevention plan was not implemented for these residents. SUGGESTED METHOD OF CORRECTION:	21990		

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21990	Continued From page 75 The facility could assure that all allegations of potential abuse are thoroughly investigated and immediately reported to the state agency and that residents are protected from potential retaliation while an investigation is pending. The Administrator, director of nursing and/or designee could assure policies are reviewed, up to date, implemented and and that staff training has been completed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the	22000		

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22000	Continued From page 76 specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement established policies and procedures to protect residents who reported allegations of potential abuse, thoroughly investigate allegations of abuse and immediately report allegations of potential abuse to the facility's administrator and state agencies for 6 of 8 residents (R1, R12, R16, R59, R63, R70) in the sample who reported allegations of abuse. Findings include:	22000		

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22000	Continued From page 77 R1, R12, R16, R59, R63 and R70 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agency. . A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. with the administrator, she was unable to produce any further documentation from any other source regarding the protection, investigation, education or training on abuse related to the specific grievance for R1, R12, R16, R59, R63 or R70 and stated, "I don't know why they weren't reported as verbal abuse." The administrator thought the grievances were dealt with but cannot produce any documentation to coincide with the resident complaints. The administrator validated the resident complaints were verbal abuse and should have been reported to the State Agency. The administrator validated the residents should have been protected pending investigation of the verbal abuse and the abuse prevention plan was	22000		

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22000	Continued From page 78 not implemented for those residents. SUGGESTED METHOD OF CORRECTION: The facility could assure established policies and procedures for abuse prevention plan are implemented, enforced and that allegations of potential abuse are thoroughly investigated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		